Parkland Medical Center

603-421-2458 ***Scheduling***

REQUEST FOR SLEEP TESTING SERVICES

FAX to 1-603-421-2293 with most recent visit notes

Patient Name: _____ DOB: _____ English Proficient? □ Yes □ No

Patient Phone Numbers: Mobile #:_____Home#:_____Height _____ Weight _____

Insurance Provider:_____Insurance ID #: _____

Please choose the interpreting physician: □ M. Laidlaw, MD □ U. Luchanok, MD □ J. Rind, MD □ No Preference

SERVICES REQUESTED

□ **Sleep Specialist Consultation and Treatment Management:** Sleep Specialist will order testing and manage treatment

□ **Diagnostic Polysomnography Only – PSG (95810)**

□ **Split Night Study (95811):** (PSG and titration in one night) with CPAP Titration (95811)

□ **All Night Titration (95811**): Titrate positive airway pressure to optimal pressure level. Dx confirmed by PSG Date: _____

□ CPAP □ Bilevel PAP □ASV (for previously diagnosed complex and central apnea)

□ **Home Sleep Apnea Test – HSAT** – Unattended Type 3 diagnostic testing

If the in-lab study is not approved and a Home Sleep Test is offered, I authorize the HST as a substitution unless "NO" is selected: □ **NO**

SPECIAL NEEDS/ASSISTANCE *(If applicable, please specify)*

INDICATION *(suspected sleep disorder)*

□ Obstructive Sleep Apnea (G47.33) □ Narcolepsy (G47.19) □ Periodic Limb Movements (G47.61)

□ Central Sleep Apnea (G47.31) □ REM Behavior Disorder (G47.52) □ Other:

COMPLAINTS

□ Excessive daytime sleepiness □ Frequent arousals/disturbed or restless sleep

□ Disruptive Snoring □ Not refreshed or rested after sleeping

SYMPTOMS *(select at least two)*

Duration of symptoms:
□ **< 2 months** □ **> 6 months**
□ **> 2 months** □ **> 1 year**

□ Witnessed apneas □ Bruxism/Teeth grinding □ Irritability

□ Waking up gasping/choking □ Nocturia □ Decreased concentration

□ Enlarged tonsils/physiological abnormalities □ Decreased libido □ Memory loss

□ Hypertension □ Leg/arm Jerking □ Other:

DOCUMENTED COMORBIDITIES & MEDICAL HISTORY: Required for In-lab Studies Only

□ Critical illness/physical impairment preventing use of portable HST

□ History of CVA (Date:_____)

□ Moderate-Severe Pulmonary Disease

□ Polycythemia

□ Moderate-Severe CHF

□ Neuromuscular weakness affecting respiratory function or activity

□ Patient prescribed opiates:

□ History of Mycardial Infarction (s/p 3mo)

□ Other:

Ordering Provider Signature:_____Date:_____

Print Name:_____NPI: _____

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