Sleep Laboratory Outpatient Order Form

Thank you for referring your patient to the Sleep Laboratory. In order to provide the best possible service to you and your patients, we are requesting the following information:

The Sleep Clinic
"Patients will be scheduled in 3 days or less"
11017 Perkins Rd Ste A BR, La 70810
3727 Canal Street Ste 1 New Orleans, LA 70019
3621 Ridge Lake Ste 204 Metairie, LA 70002
Central Scheduling (225)766-5656/(225)766-9191 fax

Patient:

Last Name _____ First Name _____

Date of Birth _____ Email Address _____

Home Phone Number _____ Mobile/Work Phone Number _____

Primary Insurance Company _____ Member ID: _____

Secondary Insurance Company _____ Member ID: _____

Referring Physician:

Last Name _____ First Name _____

Office Address (for test results) _____

City/State _____ ZIP _____

Office Phone Number _____ Office Fax Number _____

NPI: _____ Office Contact Person: _____

Practitioner's Signature _____ Date _____

SUSPECTED DIAGNOSIS

☐ G47.30
Sleep Apnea, Unspecified

☐ G47.33
Obstructive Sleep Apnea

☐ G47.61
Periodic Limb Movement Disorder

☐ G47.52
REM Behavior Disorder

☐ G47.41
Narcolepsy

☐ Other (ICD-10 codes) _____

SLEEP HISTORY/SYMPTOMS

☐ Acting out dreams
☐ Cataplexy
☐ Depression
☐ Difficulty initiating sleep
☐ Excessive daytime sleepiness
☐ Frequent nightmares
☐ Impotence
☐ Insomnia
☐ Leg movements
☐ Morning headaches
☐ Muscle/joint aches
☐ Nocturnal teeth grinding
☐ S/P surgery for OSA
☐ Sleep paralysis
☐ Sleep Walking
☐ Snoring
☐ Wakes up choking
☐ Witnessed apneas

RELEVANT MEDICAL HISTORY

☐ Anxiety disorder
☐ Arrhythmia (VT/Afib)
☐ CAD
☐ CHF
☐ Chronic Pain
☐ Claustrophobia
☐ Diabetes mellitus
☐ Fibromyalgia
☐ Hiatal hernia
☐ Hypertension
☐ Large neck or crowding of upper airway
☐ Neuromuscular weakness
☐ Obesity
☐ Pulmonary disease
☐ Pulmonary hypertension
☐ Seizure disorder
☐ Stroke
☐ Thyroid disease
☐ Other _____

PREVIOUS SLEEP STUDY?

☐ No
☐ Yes

If yes, please provide a copy of the previous sleep study with documentation stating why another sleep study is being ordered.

SPECIAL NEEDS /REQUIREMENTS

☐ Caretaker
☐ Catheter
☐ Diapers
☐ Oxygen
☐ Prosthetic
☐ Wheelchair
☐ Other _____

SUPPLEMENTAL OXYGEN WILL BE ADMINISTERED WHEN INDICATED AND AS REFERRING PHYSICIAN, YOU WILL BE NOTIFIED.

SLEEP STUDY/SERVICES REQUESTED (CHECK APPROPRIATE BOXES)

PATIENTS WILL RECEIVE A CONSULTATION WITH A SLEEP SPECIALIST UNLESS OTHERWISE INDICATED. PATIENTS DIAGNOSED WITH OSA WILL RECEIVE INFORMATION REGARDING TITRATION EQUIPMENT.

☐ Overnight Diagnostic Polysomnography 95810

☐ Positive Airway Pressure (CPAP) Titration (if indicated by PSG results) 95811

☐ Combined Overnight Polysomnography and CPAP Titration (Split Night Study) 95810/95811

☐ Narcolepsy Screen (Overnight Polysomnography followed by MSLT) 95810/95805

☐ Home Sleep Test (HST) for OSA only, high pretest probability and no co-morbidities. If HST does not meet the CMS criteria or is inconclusive, schedule in-lab Polysomnography/CPAP study 95806

☐ Ordering a sleep study to rule out the possibility of OSA

☐ Evaluation and treatment by sleep specialist

Please fax order with clinic notes and insurance information to Central Scheduling at 225-766-9191.