



2501 North Patterson St.
 Valdosta, GA 31602
 Phone: 229-259-4451
 Fax: 229-259-4452

Patient Information

Name: _____ DOB: ___/___/___ Date: ___/___/___
 Phone: _____ Cell: _____ Email: _____ M F
 Address: _____ City: _____ St: _____ Zip: _____
 Primary Insurance: _____ ID#: _____ MR#: _____

Referring Physician Information

Referring Physician: _____ Office Contact: _____
 Address: _____ City: _____ St: _____ Zip: _____
 Phone: _____ Fax: _____ NPI#: _____

Check the symptoms that best describe the patient's sleep complaint

- | | | |
|---|--|---|
| <input type="checkbox"/> Loud Snoring/Disrupted Sleep | <input type="checkbox"/> Daytime Hypersomnolence | <input type="checkbox"/> Morning Headaches |
| <input type="checkbox"/> Witnessed Apnea | <input type="checkbox"/> Non-Refreshing Sleep | <input type="checkbox"/> Sleep Paralysis |
| <input type="checkbox"/> Nocturnal Choking/Gasping | <input type="checkbox"/> Drowsy Driving | <input type="checkbox"/> Leg Jerks or Restless Legs |

Medical History

- | | | |
|---|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Acute Epilepsy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Atrial Fibrillation/SVT | <input type="checkbox"/> History of Stroke | <input type="checkbox"/> Pulmonary Hypertension |
| <input type="checkbox"/> Neuromuscular Impairment | <input type="checkbox"/> Cognitive Impairment | <input type="checkbox"/> Oxygen Dependent |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Previously diagnosed with OSA | <input type="checkbox"/> Diabetes |

Indication for study

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Periodic Limb Movement Disorder (G47.61) | <input type="checkbox"/> OSA (G47.33) | <input type="checkbox"/> Narcolepsy (G47.419) |
| <input type="checkbox"/> Central Sleep Apnea (G47.31) | <input type="checkbox"/> Other: _____ | |

Physician Order

- | | |
|---|--|
| <input type="checkbox"/> NPSG and Titration- Titration study performed upon recommendation in interpretation | <input type="checkbox"/> Titration Study |
| <input type="checkbox"/> NPSG-Diagnostic Sleep Study | <input type="checkbox"/> Multiple Sleep Latency Test-preceded by PSG |
| <input type="checkbox"/> Split Night Study- CPAP Titration is initiated according to AASM Guidelines | <input type="checkbox"/> Home Sleep Test |
| <input type="checkbox"/> Office Visit- Consultation with Sleep Physician based on documented preferences | |
| <input type="checkbox"/> Follow up and treatment by the interpreting physician-Patient's follow up and treatment plan will be based on your current preferences as documented on your Physician Profile Sheet | |

I additionally order a home sleep test (HST) for the patient if (1) it is required by the patient's insurance company or (2) There is insufficient clinical information for an attended sleep study.

I certify: That this service is medically necessary. The information provided is true, accurate and documented in the patient's clinical notes.

Physician Signature: _____ Date: _____

Fax this order, clinical notes and insurance information to: 229-259-4452