



Please fax a copy of the patient's most recent office visit notes with this form.

THE SLEEP DISORDER CENTER OF OLEAN GENERAL HOSPITAL
SLEEP STUDY ORDER FORM

Fax: 716-373-9302 PH: 716-373-9300

Must be filled out completely!

PATIENT INFORMATION
Patient: _____ DOB: _____ SS#: _____
Street: _____ City, State, Zip: _____
Home phone: _____ Work phone: _____

1. Insurance Information

a. Primary Insurance: _____
ID #: _____ Group #: _____
Subscriber: Relationship to patient: _____
Insurance Verification: Is testing covered? [] Yes [] No
Allowable: _____ CoPay Amt: _____
Referral needed? [] No [] Yes - Referral #: _____
Pre-auth. needed? [] No [] Yes - Approval #: _____
b. Secondary Insurance: _____
ID #: _____ Group #: _____
Subscriber: Relationship to patient: _____
Insurance Verification: Is testing covered? [] Yes [] No
Allowable: _____ CoPay Amt: _____
Referral needed? [] No [] Yes - Referral #: _____
Pre-auth. needed? [] No [] Yes - Approval #: _____

2. Tests ordered (please check): Note: if split night criteria are met CPAP titration will be initiated.
[] Overnight Polysomnography plus subsequent CPAP titration (if AHI is equal to or greater than 5) CPT 95810, CPT95811
[] CPAP titration
[] CPAP Repeat Titration Study - Current Settings: _____
[] BIPAP Study - Current Settings: _____
[] ASV
[] MWT Maintenance of wakefulness
[] (MSLT) Multiple Sleep Latency Test
[] Sleep consultation with Dr. Eric Tenbrock in Olean
[] Post-UPPP PSG Surgeon: _____
[] Post-oral device PSG Dentist: _____

Diet: _____

Is patient on CPAP? [] No [] Yes (current setting): _____
Is the patient currently on continuous oxygen therapy? [] No [] Yes - LPM _____
If yes, may we initiate the study on room air and initiate O2 protocol if criteria are met? [] No [] Yes
Has the patient had a previous sleep study? [] No [] Yes - when: _____
Where: _____

If not at Olean General, please send copy of report along with this form if available.
What shift does the patient work? [] Day [] Evening [] Night

3. Diagnosis:
[] Obstructive sleep apnea [] Insomnia
[] Obesity hypoventilation syndrome [] Sleep-related epilepsy
[] Periodic limb movement [] Narcolepsy
[] S/P upper airway surgery [] REM sleep behavior disorder
[] Other: _____

I, the undersigned, certify the above-prescribed procedure is medically necessary in the documentation and/or treatment of suspected diagnosis.

Physician Name (printed): _____ Signature: _____
Address: _____
Phone: _____ Fax: _____ Date: _____