

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:

- | | |
|---|--|
| <input type="checkbox"/> Obstructive sleep apnea | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Obesity hypoventilation syndrome | <input type="checkbox"/> Sleep-related epilepsy |
| <input type="checkbox"/> Periodic limb movement | <input type="checkbox"/> Narcolepsy |
| <input type="checkbox"/> S/P upper airway surgery | <input type="checkbox"/> REM sleep behavior disorder |
| <input type="checkbox"/> 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: _____