SLEEP SPECIALISTS MANAGEMENT LLC
Your Solution for Sleep Disorders
Phone (866) 337-2536

Fax to (866) 639-6551

**** REMINDER TO SEND ****

- **H&P / CLINICAL NOTES**
  DOCUMENTATION OF SLEEP DISORDER SYMPTOMS
- **PATIENT INFORMATION SHEET**
- **COPY OF INSURANCE CARD**

SLEEP STUDY PRESCRIPTION & CERTIFICATE OF MEDICAL NECESSITY

Patient Information:

Patient's Name _____ Date of Birth ___/___/___

Patient's Address _____ ❑ Male ❑ Female Biological Gender

City _____ State _____ ZIP Code _____

( ) Patient's Cell Phone Number _____ ❑ YES ❑ NO Receive Text Messages?

( ) Patient's Alternate Phone Number (Home / Work / Other) _____ ❑ Home ❑ Work ❑ Other _____

Referring Physician Information *(PLEASE PRINT)*:

Referring Physician's Name *(PRINT REQUIRED)* _____

Referring Physician's Address _____

City _____ State _____ ZIP Code _____

TIN / EIN _____ ( ) Referring Physician's Phone Number _____

NPI _____ ( ) Referring Physician's Fax Number _____

DIAGNOSIS *(Required)*

❑ G47.33 – Obstructive Sleep Apnea
❑ E66.2 – Morbid (Severe) Obesity with Aveolar Hypoventilation
❑ F51.11 – Primary Hypersomnia
❑ G47.10 – Hypersomnia, Unspecified
❑ G47.30 – Sleep Apnea, Unspecified
❑ G47.31 – Primary Central Sleep Apnea
❑ G47.441 – Narcolepsy With Cataplexy
❑ G47.419 – Narcolepsy Without Cataplexy
❑ G47.50 – Parasomnia, Unspecified
❑ G47.61 – Periodic Limb Movement Disorder (PLMD)
❑ G47.8 – Other Sleep Disorders
❑ Other Diagnosis: _____

SLEEP SERVICE ORDER *(Must check at least one)*

❑ Diagnostic PSG with Second Night PAP Titration as indicated on PSG Interpretation[1,2] or Identify Individual Study:

❑ 95810 – Diagnostic Sleep Study (PSG)[2]
❑ 95800 / 95800 – Multiple Night Home Sleep Test
  • May Substitute G0399 or 95806 if required by insurance.
❑ 95811 – Split Night Study[1,2]
❑ 95811 – PAP Titration[1]
  • Include Prior Sleep Study Results
❑ 95805 – MSLT
  • Preceded by Overnight Sleep Study (95810)
❑ 95805 – MWT
  • Preceded by Overnight Sleep Study (95810)

[1]CPAP/Bi-Level at a pressure setting as was found to be the "Optimal Pressure" directly following an overnight PAP Titration Study.
[2]May substitute Multiple Night HST for PSG if required by insurance or requested by patient.

ASSESSMENT / INDICATIONS *(Check all that apply. A minimum of one in BOLD is needed to qualify)*

❑ **Witnessed Apnea / Gasping During Sleep**
❑ **Disruptive / Loud Snoring**
❑ **Excessive Daytime Sleepiness**
❑ **Hypertension / High Blood Pressure**
❑ **Restless Sleep With Limb Movements**
❑ **Unable To Perform Home Test**
❑ Diabetes
❑ CHF EF _____
❑ BMI ≥ 50 (Morbid Obesity)
❑ Sleep Walking / Talking / Parasomnias
❑ CVA / Stroke
❑ Nasal Obstruction
❑ Low Energy / Fatigue
❑ Morning Headaches
❑ Depression
❑ Heart Disease MI _____
❑ COPD FEV _____
❑ Anxiety
❑ Central Sleep Apnea
❑ Other: _____

SLEEP QUESTIONNAIRE

Neck Circumference = _____ inches

Epworth Sleepiness Score = _____ (A score ≥ 10 indicates moderate to high probability of OSA.)

I hereby authorize the indicated services above, within standard clinical policies and procedures. I personally conducted a physical medical examination of the patient named above for complaints of sleep disorders or other disease. The patient displayed symptoms of one or more sleep-related breathing disorders indicated above. Accordingly, I am ordering a sleep study be conducted as indicated here.

Physician's Signature *(REQUIRED)* _____ Date *(REQUIRED)* ___/___/___ Time *(REQUIRED)* ___:___ ❑ AM ❑ PM Person Completing Medical Necessity Form *(PRINT REQUIRED)* _____

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SELF-SCORING SLEEP QUESTIONNAIRE

Patient's Name _____ Date of Birth / / _____ Physician's Name _____

( ) _____ Patient's Cell Phone ( ) _____ Patient's Other Phone _____ Health Insurance Company

SLEEP DISORDER RISK ASSESSMENT

This self-scoring questionnaire was developed as a guideline to help identify sleep disordered breathing problems. Please check (✓) the appropriate box to the left of each symptom if you have experienced that symptom on a regular basis. Your doctor will discuss these results with you during your visit.

	1. I have been told that I snore.
	2. I have been told that I stop breathing or hold my breath when I sleep, although I may have no recollection of this. (Witnessed Apnea)
	3. I am always sleepy during the day, even when I have slept throughout the night (I wish I had more energy).
	4. I have high blood pressure, or am being treated for high blood pressure.
	5. I have Type 2 Diabetes.
	6. I have been told that I sleep restlessly. I am always "tossing and turning".
	7. I wake up frequently to use the bathroom (frequent urination).
	8. I frequently awaken with headaches in the morning.
	9. I tend to fall asleep during inappropriate times.
	10. Others have noticed a change in my personality (often grumpy / irritable).
	11. I am overweight or have recently gained weight.
	12. I suddenly wake up gasping for breath at times.
	= **TOTAL NUMBER OF CHECK MARKS**

SCORING: If you have **marked 3 or more boxes**, you show **symptoms of Sleep Apnea**, a life-threatening sleep disorder that causes you to stop breathing during your sleep. If you are experiencing any of these symptoms, please ask your doctor to refer you for a sleep study.

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling "just tired"? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation.

0 = Would never doze. 1 = Slight chance of dozing. 2 = Moderate chance of dozing. 3 = High chance of dozing.

Score	Situation
	1. Sitting and reading.
	2. Watching television.
	3. Sitting inactive in a public place (i.e. theater or meeting).
	4. As a passenger in a car for an hour without a break.
	5. Lying down to rest in the afternoon when circumstances permit.
	6. Sitting and talking quietly to someone.
	7. Sitting quietly after lunch without alcohol.
	8. In a car, while stopped for a few minutes in traffic.
	= **TOTAL EPWORTH SCORE**

Analyze your score:

0-7: It is unlikely that you are abnormally sleepy.

8-9: You have an average amount of daytime sleepiness.

10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.

16-24: You are excessively sleepy and should consider seeking medical attention.