SleepMed

Providence HEALTH

SLEEP DISORDERS CENTER

PROVIDENCE DOWNTOWN OR PROVIDENCE NORTHEAST

Physician's Prescription & Certificate of Medical Necessity

For Diagnosis and Treatment of Sleep Disorders

PH: 866.726.5031 **FAX: 877.479.3625**

Patient Information

Legal Name (Last, First, MI): _____ SSN: _____

Address: _____ DOB: _____ Male/Female _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status _____ Race: _____ Height: _____ Weight: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Please fax a copy of this completed form, a front and back copy of the patient's insurance card and patient's office notes.

Procedure Orders: Check ONE

☐	**Baseline Polysomnography (First Night)**	**CPT 95810**
☐	**Split Night (Diagnostic; Add PAP if criteria is met)**	**CPT 95811**
☐	**CPAP Titration (Second Night)**	**CPT 95811**
☐	**Bi-Level Titration (Second or Additional Night)**	**CPT 95811**
☐	**Multiple Sleep Latency Test (Day Study after PSG)**	**CPT 95805**
☐	**MSLT Urine Drug Screen**	

Post-Sleep Study Consultation Request:

☐ **Refer to Dr. Hina Chaudhry AFTER sleep study for diagnosis, treatment, equipment setup and ongoing follow up care.** *(Please select one procedure order above)*

SPECIAL NEEDS:

☐ **Oxygen** ☐ **Nasal Cannula** ☐ **Mask** _____ **LPM**

☐ **Wheel chair**

☐ **Handicapped/ Disabled**

☐ **> 450 LBS**

☐ **Other:** _____

Preliminary Diagnosis:

☐ G47.33 Obstructive Sleep Apnea

☐ _____ Other: _____

Clinical Symptoms: Check ALL that apply

- ☐ Witnessed Apnea – gasping episodes during Sleep
- ☐ Hypertension
- ☐ Excessive Daytime Sleepiness
- ☐ Falling Asleep While Driving
- ☐ Impaired Memory/Concentration
- ☐ Insomnia
- ☐ Loss of Muscle Control (Cataplexy)
- ☐ Loud Snoring
- ☐ Mood Disorder
- ☐ Morning Headaches
- ☐ Obesity
- ☐ Pulmonary Disease
- ☐ Restless Legs
- ☐ Other: _____

COMMENTS:

_____

_____

Ordering Physician Information:

Physician Name: _____ NPI #: _____

Address: _____ Specialty: _____

Phone/Cell: _____ Fax: _____ Email: _____

The above referenced patient has an absolute medical necessity for the item(s) listed above, based on the above preliminary diagnosis. I certify that the above prescribed item(s) is/are medically indicated and, in my opinion, reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition. I acknowledge that when I send a patient directly to the Providence Hospitals Sleep Center for a sleep study without a follow up visit with the interpreting physician, I will be responsible for reviewing the test results with the patient, and when appropriate will be ordering medical necessary treatment for this patient.

Ordering Physician's Signature: _____ **Time:** _____ Date: _____

APPOINTMENT DATE: _____ APPOINTMENT TIME: _____

WHICH PROVIDENCE DIAGNOSTIC SLEEP CENTER LOCATION?:: _____ Downtown Columbia _____Northeast Columbia