PROVIDENCE HEALTH
Sleep Disorder Center

Downtown – Northeast

Providence

MIDLANDS PULMONARY • CRITICAL CARE
SLEEP MEDICINE

Physician's Prescription & Certificate of Medical Necessity

For Diagnosis and Treatment of Sleep Disorders

PHN: 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

☐	**Polysomnography (PSG)**	**First Night Study**	**CPT 95810**
☐	**CPAP Titration**	**Second Night Study**	**CPT 95811**
☐	**Bi-Level Titration**	**Second Night Study**	**CPT 95811**
☐	**Multiple Sleep Latency Test**	**Day Study**	**CPT 95805**
☐	**MSLT Urine Drug Screen**	**Dx: Excessive Daytime Sleepiness**	
☐	**Other:** ______________		**CPT:** ______

Referral to Sleep Specialist after PSG for diagnosis and treatment:

- ☐ **Dr. Luis DeLaCruz**
- ☐ **Dr. Chandar Abboy**
- ☐ **Dr. Farhan Siddiqui**

Special Needs:

Does patient have special needs? ______________________

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Preliminary Diagnosis:

☐ **G47.33 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 CV Disease: ______________
- ☐ Other: ______________

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: ______________

LOCATION: ______________________________________