



SLEEP STUDY & TREATMENT ORDER FORM

Massachusetts
Phone: 781-740-9155
Referral Fax: 781-740-9156

Rhode Island
Phone: 401-541-9188
Referral Fax: 401-541-9199

Locations Across Massachusetts, Rhode Island, & Connecticut

PATIENT INFORMATION

Name: _____ DOB: _____ Gender: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell: _____ Email: _____
 Primary Insurance: _____ Insurance #: _____

**Suspected Disorders/Diagnosis
(Please check all that apply)**

- Obstructive Sleep Apnea (OSA)
- Insomnia
- Nocturnal Seizures/parasomnia
- Restless leg syndrome (RLS) or Periodic Limb movements of sleep (PLMS)
- Narcolepsy

**Primary Symptoms
(Please check all that apply)**

- Snoring/gasping /choking
- Witnessed Apneas
- Obese /Large neck
- Daytime Fatigue
- Difficulty Falling Asleep
- Frequent Awakening/Fragmented Sleep

- Frequent leg movements during sleep
- S/P Airway Surgery
- Hypertension
- Depression/Mood Disorders
- Other _____

PLEASE PROVIDE MOST RECENT CLINICAL NOTES REGARDING SUSPECTED SLEEP DISORDER.

DIAGNOSTIC TESTING & TREATMENT

DIAGNOSTIC TEST TYPES

Home Sleep Apnea Test

- If Test is Positive for G47.33 Obstructive Sleep Apnea,
Please Provide Therapy Type: APAP (4-20CM H2O)
Humidification: Heated • Length of Need: 99 Months

- Standard In Lab Sleep Study
- Split Night in Lab Study (Sleep Study and Pap Titration)
- CPAP/Bilevel Titration
- MSLT (Daytime Sleep Study in Lab preceded by full night Sleep Study)

Order includes all supplies and accessories necessary for the compliant use of the prescribed equipment

E0562 humidifier, heated A7031 Full Face Cushion A7036 Chinstrap A7044 Oral mask A7027 Oral/nasal mask A7032 Nasal cushion A7037 Tubing A7046 Humidifier chamber A7028 Oral/Nasal Cushion A7033 Nasal Pillow A4604 Tubing-heated A7029 Oral/Nasal pillows A7034 Nasal mask A7038 Filter-disp A7030 Full Face mask A7035 Headgear A7039 Filter-reusable

SLEEP MEDICINE SPECIALIST FOR CONSULTATION

EPWORTH SLEEPINESS SCALE - MUST BE COMPLETED FOR PRECERTIFICATION Height _____ Weight _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

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

- 0 = no chance of dozing
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Situation	Chance of Dozing	Scale	Situation	Chance of Dozing	Scale
Sitting and reading		<input type="checkbox"/>	Laying down to rest in the afternoon		<input type="checkbox"/>
Watching TV		<input type="checkbox"/>	Sitting and talking to someone		<input type="checkbox"/>
Sitting inactive in a public place		<input type="checkbox"/>	Sitting quietly after lunch (without alcohol)		<input type="checkbox"/>
Being a passenger in a car for an hour without a break		<input type="checkbox"/>	Sitting for a few minutes in traffic while driving		<input type="checkbox"/>

Total score equals your EES

PROVIDER INFORMATION

Referring Physician /NP/PA Name: _____

Physician /NP/PA Signature _____ Date _____

Phone: _____ Fax: _____

Primary Care Physician Name: _____ NPI: _____

FOR SLEEP CENTER ONLY
 Check if physical exam is listed in referring M.D.'s notes
 History reviewed by _____ M.D.
 Date ____/____/____