

330 Military Cutoff Rd Unit B1
Wilmington, NC 28405
Phone: 910-313-0541
Fax: 1-877-897-0672



1090 Medical Center Drive
Wilmington, NC 28401
Phone: 910-313-0541
Fax: 1-877-897-0672

Patient Information

Name: _____ DOB: ____/____/____ Date: ____/____/____
Phone: _____ Cell: _____ Email: _____ M F
Address: _____ City: _____ St: _____ Zip: _____
Primary Insurance: _____ ID#: _____ Ht: _____ Wt: _____ Neck: _____

Referring Physician Information

Referring Physician: _____ Office Contact: _____
Address: _____ City: _____ St: _____ Zip: _____
Phone: _____ Fax: _____ NPI#: _____

Check the symptoms that best describe the patient's sleep complaint

- | | | |
|---|--|---|
| <input type="checkbox"/> Loud Snoring/Disrupted Sleep | <input type="checkbox"/> Daytime Hypersomnolence | <input type="checkbox"/> Morning Headaches |
| <input type="checkbox"/> Witnessed Apnea | <input type="checkbox"/> Non-Refreshing Sleep | <input type="checkbox"/> Sleep Paralysis |
| <input type="checkbox"/> Nocturnal Choking/Gasping | <input type="checkbox"/> Drowsy Driving | <input type="checkbox"/> Leg Jerks or Restless Legs |

Medical History

- | | | |
|---|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Acute Epilepsy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Atrial Fibrillation/SVT | <input type="checkbox"/> History of Stroke | <input type="checkbox"/> Pulmonary Hypertension |
| <input type="checkbox"/> Neuromuscular Impairment | <input type="checkbox"/> Cognitive Impairment | <input type="checkbox"/> Oxygen Dependent |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Previously diagnosed with OSA | <input type="checkbox"/> Epworth _____ |
| <input type="checkbox"/> Diabetes | Special Instructions _____ | |

Indication for study/DX OSA (G47.33) Primary CSA (G47.31) Complex CSA (G47.37) Hypersomnia, Unspecified (G47.10)
 PLMD (G47.61) Sleep Apnea, Unspecified (G47.30) Narcolepsy w/ Cataplexy (G47.11) w/o Cataplexy (G47.419) Other: _____

Physician Order

- | | |
|---|--|
| <input type="checkbox"/> NPSG and Titration- Titration study performed upon recommendation in interpretation | |
| <input type="checkbox"/> NPSG-Diagnostic Sleep Study | <input type="checkbox"/> Titration Study: _____ |
| <input type="checkbox"/> Split Night Study- CPAP Titration is initiated according to AASM Guidelines | <input type="checkbox"/> Multiple Sleep Latency Test-preceded by PSG |
| <input type="checkbox"/> Office Visit- Consultation with a SleepCare Provider | <input type="checkbox"/> Proceed w/ MSLT if AHI is < ____ & PLM's are < ____ |
| <input type="checkbox"/> Follow up and treatment by the interpreting physician | <input type="checkbox"/> Home Sleep Test |
| <input type="checkbox"/> I additionally order a home sleep test (HST) for the patient if (1) it is required by the patient's insurance company or (2) There is insufficient clinical information for an attended sleep study. | |

I certify: That this service is medically necessary. The information provided is true, accurate and documented in the patient's clinical notes.

Physician Signature: _____ Date: _____

Fax this order, clinical notes and insurance information to: 1-877-897-0672