



For Sleep Consultations

Phone 770-586-0300

Fax 770-586-0311

www.pulmonarysleepmed.com

For Sleep Study only

Fax order to 1-800-381-6954

****Please attach a legible copy of patient's information sheet****

Patient Name: _____ M/F _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

SS# _____ DOB _____ HT _____ WT _____ Neck Size _____

Guarantor (if other than the patient) _____

Prior sleep study Yes No When _____

Is patient on CPAP Yes No If yes _____ cm H2O

Is patient on home oxygen Yes No If yes _____ lpm

Is the patient on sleep aide Yes No If yes Sleep aide _____

Will the patient be prescribed a sleep aide for the night of the study? Yes No

History: (please check any applicable)

___ Snoring ___ Irregular/gasping breaths ___ Hypertension

___ Daytime sleepiness ___ Obesity ___ Diabetes

___ Restless limbs ___ Witnessed Apneas ___ Other _____

___ Shortness of breath ___ Heart Disease _____

Study requested (REQUIRED)

___ Polysomnography Initial 95810

___ Polysomnography CPAP Titration 95811

___ Multiple Sleep Latency Test (MSLT) 95805

___ Sleep Consultation

Diagnosis (REQUIRED)

___ Obstructive sleep apnea 327.23

___ Insomnia w/Sleep Apnea 780.51

___ Hypersomnia w/Sleep Apnea 780.5

___ Narcolepsy 347.00

___ Unspecified Sleep Apnea 780.57

___ Other _____

___ If interpreting physician recommends additional sleep testing (CPAP/BIPAP titration or repeat testing)

I authorize SleepHealth to contact patient to schedule

Special Needs of Patient _____

Physician Name: _____ Specialty: _____

Phone: _____ Fax : _____

Physician NPI # _____

Office Contact: _____

Physician signature _____ Date _____