SLEEP STUDY REFERRAL/ORDER FORM
FAX TO: 916-482-3647

SLEEP LABORATORY

To better serve you and your patients, please provide the following information:

PATIENT NAME:		**DOB:**	**Phone Number:**	
Address:		City:	State:	Zip:
Height:	Weight:	BMI:	Age:	

Patient's Primary / Secondary Insurance	**Name of Insured (*if not patient*):**	
Primary Insurance Name:	Group #	ID #
Secondary Insurance Name:	Group #	ID #

Ordering Provider:	Address:
Specialty:	City:
Phone:	State: Zip:
Fax [to send patient test results]:	E-mail:

<u>PROVIDER ORDERS:</u>

PROCEDURE/PROCEDURE CODE (PLEASE CHECK ONE):

☐ Polysomnography Study Only **– NO CPAP TITRATION**	**95810**
☐ Polysomnography Study w/CPAP titration per protocol **(SPLIT NIGHT)**	**95810/95811**
☐ All Night PAP Titration ___CPAP ___BiPAP ___ASV	**95811**
☐ Polysomnography **PEDIATRIC < 6 YRS – NO CPAP TITRATION**	**95782**
☐ Polysomnography Study w/MSLT **(R/O NARCOLEPSY)**	**95810 & 95805**
☐ HSAT (Home Sleep Apnea Test) Type III Unattended **(SCREENING)**	**95806**
☐ OTHER: ____	

Provider Signature:______________________________________ **Date:___________**

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PATIENT NAME:	**DOB:**

Sleep Symptoms/Clinical Indications (check all that apply)

☐ Witnessed apneas	☐ Habitual snoring	☐ Excessive Daytime Sleepiness (EDS)
☐ Morning headaches	☐ Sleep fragmentation	☐ Epworth Sleepiness Scale ≥10, Score _____/24
☐ Choking / Gasping	☐ Daytime fatigue	☐ Other____

Complete this section if this is a <u>REPEAT TEST</u>: Prior diagnosis of apnea? ☐ No ☐ Yes (if **yes**, Test Date:___________)

☐ Weight gain/loss > 10% ☐ Evaluate efficacy ☐ Evaluate need to continue therapy ☐ Prev. inconclusive HSAT

Type of Treatment: ☐ Surgery ☐ Oral Appliance ☐ PAP ☐ Other ___________________________

Additional Information:

Required Documentation (check off):

- ☐ **<u>Completed</u>** sleep study referral/order form.
- ☐ Order **<u>MUST</u>** be signed and dated.
- ☐ Clinical chart notes/consultation with **relevant medical history** documenting the **indication for testing** from the patient encounter when the sleep test was ordered.
- ☐ Complete list of current medications, including allergies.
- ☐ Copy of insurance card(s).

Fax all required Documentation to 916-482-3647

Additional Information:

1. The ordering provider must complete, sign and date the referral/order form.
2. Please mark all clinical indications that apply to your patient on referral/order form.
3. If you are re-testing a patient it is important to indicate the purpose of the retest.

Additional Information (HSAT):

1. All patients will have telephone access to a licensed sleep technologist 24 hours a day.
2. The home sleep apnea test kit includes: step by step visual instructions, URL link to the instructional video, sleep questionnaire (pre and post), patient authorization form and pre-paid postage and packaging materials for return shipment (if shipping to patient's home).
3. Home Sleep Apnea Test (HSAT) has a **15 to 20% false negative rate**. If the Apnea Hypopnea Index (AHI) is low and the patient has complaints of symptoms, they should be referred for an overnight in lab polysomnography (PSG).
4. HSAT is a limited unattended screening for Obstructive Sleep Apnea (OSA), it is **NOT** used to diagnose:
    a. Central Sleep Apnea or treatment emergent Central Apnea
    b. Narcolepsy
    c. Complex Parasomnias with potential injurious disruptive or violent behavior such as REM Behavior Disorder or Sleep Walking
    d. Periodic Limb Movements
    e. Obesity Hypoventilation Syndrome with $pCO_2 > 45$ mmHg and $pO_2 < 60$ mmHg
    f. Nocturnal seizures
5. Patients tested with HSAT must have a high pre-test probability of OSA with limited co-morbidities. The following may exclude a patient from acceptance for HSAT testing:
    a. Neuromuscular disorders,
    b. Severe to very severe COPD
    c. CHF w/EF ≤ 45%,
    d. Supplemental oxygen
    e. Moderate to severe pulmonary hypertension with pulmonary artery pressure > 40mmHG
    f. Uncontrolled cardiac arrhythmias
    g. Cognitive impairment that prevents the patient from home sleep testing

Office Pick-up: Upon receipt of the required documentation our sleep coordination team will contact your patient to complete the registration process and schedule a pick-up date at our Downtown Sacramento or Roseville office anytime between 9am – 4pm.

PULMONARY MEDICINE ASSOCIATES
1508 ALHAMBRA BLVD
SACRAMENTO, CA 95816
PHONE#: 916-325-1040

PULMONARY MEDICINE ASSOCIATES
5 MEDICAL PLAZA DRIVE, #190
ROSEVILLE, CA 95661
PHONE#: 916-786-7498

Ship to Home: If pickup from our Sacramento or Roseville location is not an option, upon receipt of the required documentation our sleep coordination team will arrange for shipment of the sleep recording device via USPS 2-day Priority Mail.