AllCare SLEEP CENTER

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Medicare Accredited Facility

Physician Order Form

Patient Information

Patient Name:_____ M / F DOB: _____

Home Phone:_____ Cell Phone: _____ Email:_____

Insurance:_____ Insurance ID #:_____

- ☐ **Consultation and Management with a Sleep Physician** ☐ Pre ☐ Post
  (Evaluation for possible sleep disorders with a board certified sleep physician)
- ☐ **Full Night Polysomnogram (PSG)**
  (Attended Diagnostic Sleep Study, CPT 95810) * If positive study, CPAP titration to be done on separate night
- ☐ **Full Night CPAP/BiPAP Titration Study**
  (For patients with documented sleep apnea; CPT 95811)
- ☐ **Split Full Night Sleep Study (50/50)**
  (Part 1: Diagnostic, Part 2: CPAP Titration; CPT 95811)
- ☐ **Multiple Sleep Latency Test (MSLT)**
  (Daytime nap test to rule out narcolepsy or idiopathic hypersomnolence; CPT 95805)
- ☐ **Home Sleep Study** ☐ 1 Night ☐ 2 Nights ☐ 3 Nights
  (Unattended home sleep study; CPT 95806) *At least two nights recommended for better results.
- ☐ **Other Study:** _____

Medical History

Signs/Symptoms: *Check Box(s)*

☐ Loud Snoring ☐ Witnessed Apnea ☐ Daytime Sleepiness ☐ Pulm HTN/COPD ☐ High BP

☐ Restless Sleeper ☐ Obesity ☐ Morning Headaches ☐ Frequent Awakenings ☐ CHF

Other:_____

Diagnosis: *Check Box(s)*

☐ Somnolence (780.09) ☐ Sleep Apnea (unspec) (780.57) ☐ Narcolepsy (347) ☐ Tiredness (780.53)

☐ Insomnia with Apnea (780.51) ☐ Hypersomnia with apnea (780.53) ☐ Hypersomnia unspec (780.54)

☐ Periodic Limb Movement Disorder (327.51) ☐ Other Sleep Disturbance (780.59)

Other_____

Other Past Medical History_____

Ordering Physician

Name:_____Phone:_____Fax:_____

Physician Signature:_____Date:_____

Please fax orders to 818 - 857-5337 (818-85-SLEEP)