

SLEEP STUDY & TREATMENT ORDER FORM

Massachusetts

Phone: (774) 992-7251 | Fax: (774) 992-7693
(781) 740-9155 | (781) 740-9156

Rhode Island

Phone: (401) 541-9188 | Fax: (401) 541-9199

PATIENT INFORMATION

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

SUSPECTED DISORDERS/DIAGNOSIS

(Please check all that apply)

- Obstructive Sleep Apnea (OSA) 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 Obese/Large Neck Difficulty Falling Asleep Frequent Leg Movements During Sleep Depression/Mood Disorders
 Witnessed Apneas Daytime Fatigue Frequent Awakening/Fragmented Sleep Hypertension Other _____

DIAGNOSTIC TESTING & TREATMENT OPTIONS

- Home Sleep Apnea Test
 Sleep Medicine Tele-Consultations
 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)
Sleep Medicine Specialist for Consultation Only (Now Providing Sleep Medicine Tele-Consultations)

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

PROVIDER INFORMATION

Referring Physician/NP/PA Name: _____

 Physician/NP/PA Signature _____ Date _____

Phone: _____ Fax: _____

Primary Care Physician Name: _____ NPI: _____

<p>FOR SLEEP CENTER ONLY Check if physical exam is listed in referring M.D.'s notes <input type="checkbox"/> History reviewed by _____ M.D. Date ____/____/____</p>
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Please Provide Most Recent Clinical Notes Regarding Suspected Sleep Disorder