"Your Sleep Disorders Specialists"

Rocky Mountain
SLEEP DISORDERS CENTER
LLC

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ORDER FOR SLEEP TESTING

Patient Name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Male☐☐ Female☐☐ Height: _____ Weight: _____ Notes: _____

Primary Insurance: _____ ID: _____ Group: _____

Secondary Insurance: _____ ID: _____ Group: _____

My patient has the following symptom(s):

_____ Snoring
_____ Nighttime Sweats
_____ Morning Headaches
_____ Apnea (*witnessed by* _____)

_____ Hypertension
_____ Frequent Awakenings
_____ Other: _____
_____ Excessive Daytime Sleepiness

_____ Symptoms of Narcolepsy
_____ Morning Headaches
_____ Limb Movements

_____ Obesity
_____ Marked Insomnia
Other: _____

I would like to order the following service(s) for my patient:

_____ Complete Sleep Testing (*Polysomnogram and CPAP or Bi-Pap Titration, if indicated*)

_____ Polysomnogram
_____ CPAP/Bi-Pap Titration
_____ Overnight Oximetry

_____ MSLT (must be proceded by PSG)
_____ MWT(must be proceded by PSG)
_____ Bright-Light Therapy

_____ Sleep Physician Consultation
_____
_____ PFT Basic

_____ Equipment/Mask Consultation
_____ Holter Monitor 48-Hour_____ 24-Hour _____

Please include a copy of your patient's most recent medical history and a copy of your patient's insurance card(s), if any.

If you feel you will need a sleep aide for testing please consult your ordering physician for an order for Lunesta or Ambien to bring to the scheduled apt.

LETTER OF MEDICAL NECESSITY

The symptom(s) checked above are consistent with the presence of a sleep disorder, which could possibly be life-threatening. These findings warrant the medical necessity of an overnight polysomnographic evaluation of this patient to assess the presence and severity of the sleep disorder.

Provider Signature: _____ Date: _____

Printed Name: Phone: Fax: UPIN: