Beth Israel Lahey Health
Beth Israel Deaconess Milton

Sleep Testing oneForm Request
Please fax completed form with most recent office notes to: 617-796-9099
For questions, please call: 617-796-7766

DEMOGRAPHIC INFORMATION

Patient Name:_____DOB:_____ English Proficient? □ Yes □ No

Patient Phone Numbers: Mobile #:_____Home#:_____Alternate #: _____

Insurance Provider:_____Insurance ID #: _____

SLEEP STUDY REQUESTED

☐ **Polysomnography – PSG (95810):** All night attended diagnostic sleep study (PSG) to evaluate for all sleep disorders.

☐ **Split Night Study (95811):** Attended testing including CPAP initiation & titration. If titration criteria met with less than three hours testing remaining, a new order for an all-night PAP titration study will be required. Refer to interpretation report.

☐ **PAP Titration*** **(95811**): Titrate positive airway pressure to optimal pressure level.
OSA must be previously documented by a PSG.* **Date of PSG: _____

☐ **Home Sleep Apnea Test – HSAT** Unattended Type 3 diagnostic testing. Recommended ONLY for patients with high likelihood of ObstructiveSleep Apnea (OSA). Provider: Neurocare, Inc. (TIN: 043032581)

If the in-lab study is not approved and a Home Sleep Test is offered, I authorize the HST as a substitution unless "NO" is selected: □ **NO**

SPECIAL NEEDS/ASSISTANCE *(If applicable, please specify)*

☐ Supplemental Oxygen (*if selected, HSAT cannot be performed*)

INDICATION *(suspected sleep disorder)*

☐ Obstructive Sleep Apnea (G47.33)
☐ Central Sleep Apnea (G47.31)
☐ Narcolepsy (G47.419)
☐ REM Behavior Disorder
☐ Periodic Limb Movements (G47.61)
☐ Other

PATIENT COMPLAINTS *(select at least one)*

☐ Excessive daytime sleepiness
☐ Disruptive snoring
☐ Frequent arousals/disturbed or restless sleep
☐ Not refreshed or rested after sleeping

SYMPTOMS (select at least two)

Duration of Symptoms: ☐ **< 6 months** ☐ **>6 months**

☐ Witnessed apneas
☐ Waking up gasping/choking
☐ Decreased concentration
☐ Memory Loss
☐ Enlarged tonsils/physiological abnormalities compromising respiration
☐ Leg/arm jerking
☐ Bruxism/teeth grinding during sleep
☐ Nocturia
☐ Decreased libido
☐ Hypertension
☐ Irritability
☐ Other:

DOCUMENTED COMORBIDITIES & MEDICAL HISTORY

☐ Critical Illness or physical impairments
☐ Preventing use of portable HST device
☐ Moderate to severe Congestive Heart Failure
☐ Moderate to severe pulmonary disease
☐ History of Myocardial infarction (s/p 3 mos.)
Date: _____
☐ Neuromuscular weakness affecting respiratory function or impairing activity (please specify: _____)
☐ Patient prescribed opiates: _____
☐ Polycythemia
☐ Other

I acknowledge that the clinical information submitted to support this request is accurate and specific to this patient, and all information has been provided.
I authorize submission of this information for precertification on my behalf.

Ordering Provider Signature:_____Date:_____

Print Name:_____NPI: _____

Beth Israel Deaconess Hospital, Milton ● 199 Reedsdale Rd, Milton, MA 02186 ● Phone: 617-796-7766 ● Fax: 617-796-9099 ● www.neurocareinc.com