



# -SLEEP STUDY INTAKE FORM-

## Fax To: 888-765-6615

<b>Patient Information</b>		<b>Insurance Information</b>	
Patient Name:		Insurance Company:	
Contact Home Phone:		I.D. #	
Contact Work/Cell Phone:		Insurance Phone:	
Address:		Insured Name:	
City/State/Zip:		PCP:	
DOB:	Sex: M / F	PCP Tel #	

<b>Facility Information</b>	
Facility Name	Facility Code:

**VERIFICATION OF MEDICAL NECESSITY:**

TYPE OF STUDY REQUESTED:	PATIENT REFERRED FOR EVALUATION OF:
<input type="checkbox"/> Nocturnal Polysomnogram (NPSG) 95810	<input type="checkbox"/> Obstructive Sleep Apnea 327.23 <input type="checkbox"/> RLS/PLMD 327.51
<input type="checkbox"/> CPAP titration for OSA [no ETCO <sub>2</sub> ] 95811	<input type="checkbox"/> Central Sleep Apnea 327.3 <input type="checkbox"/> Narcolepsy 347
<input type="checkbox"/> BPAP titration for OSA [no ETCO <sub>2</sub> ] 95811	<input type="checkbox"/> Hypoventilation 327.26 <input type="checkbox"/> Parasomnias 327.40
<input type="checkbox"/> BPAP titration for hypoventilation [with ETCO <sub>2</sub> ] 95811	<input type="checkbox"/> Unexplained drowsiness 327.10 <input type="checkbox"/> Insomnia 327.00
<input type="checkbox"/> Split night study (NPSG/CPAP if AHI >=20)	<input type="checkbox"/> Unspec. Sleep Disturbance 780.50
<input type="checkbox"/> Multiple sleep Latency Test (MSLT) 95805	<input type="checkbox"/> Post-operative evaluation: _____ Other: _____
<input type="checkbox"/> Home Sleep Study Unattended (HST) 95806	<input type="checkbox"/> Simultaneous recording of heart rate, oxygen saturation, respiratory airflow and respiratory effort
<input type="checkbox"/> Insomnia 95827	<input type="checkbox"/> Electroencephalogram (EEG) all night recording

**Reason for Referral:**

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**Special Instructions:**

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**Progress Notes:** *(Progress notes of the patient's condition is to be attached)*

**History:**

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\*\*\*\*(OFFICE USE ONLY) \*\*\*\*

**MEDICAL DIRECTOR REVIEW:** \_\_\_\_\_ "By Signing you are attesting you have seen this patient face-to face and have patient notes on file that support the indicators selected above. For Medicare patients you are attesting the face to face evaluation met all applicable Medicare statutory and regulatory requirements."

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**STOP BANG Questionnaire**



Height \_\_\_\_\_ inches/cm Weight \_\_\_\_\_ lb/kg

Age \_\_\_\_\_

Male/Female

BMI \_\_\_\_\_

Collar size of shirt S, M, L, XL, or \_\_\_\_\_ inches/cm

Neck circumference\* \_\_\_\_\_ cm

**1. Snoring**

Do you snore loudly (louder than talking or loud enough to be heard through closed doors?)

Yes \_\_\_ No \_\_\_

**2. Tired**

Do you often feel tired, fatigued, or sleepy during daytime?

Yes \_\_\_ No \_\_\_

**3. Observed**

Has anyone observed you stop breathing during your sleep?

Yes \_\_\_ No \_\_\_

**4. Blood pressure**

Do you have or are you being treated for high blood pressure?

Yes \_\_\_ No \_\_\_

**5. BMI**

BMI more than 35 kg/m?

Yes \_\_\_ No \_\_\_

**6. Age**

Age over 50 yr old?

Yes \_\_\_ No \_\_\_

**7. Neck circumference**

Neck circumference greater than 40 cm?

Yes \_\_\_ No \_\_\_

**8. Gender**

Gender male?

Yes \_\_\_ No \_\_\_

\*Neck circumference is measured by staff

High risk of OSA: answering yes to three or more items

Low risk of OSA: answering yes to less than three items

Adapted from:

STOP Questionnaire

A Tool to Screen Patients for Obstructive Sleep Apnea

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**SLEEP HISTORY:** Does, or has, the patient:

Often wake up with a morning headache?	YES ___	NO ___
Snore regularly/excessively during sleep?	YES ___	NO ___
Been observed to have pauses inbreathing pattern during sleep?	YES ___	NO ___
Awaken with gasping, choking, dry mouth or throat?	YES ___	NO ___
Tend to be a mouth breather?	YES ___	NO ___
Experience a restless sensation in arms or legs during sleep or in the evening?	YES ___	NO ___
Been told that they make kicking movements during sleep?	YES ___	NO ___
Have difficult' falling asleep at the beginning of the night?	YES ___	NO ___
Have difficulty staying awake during the day?	YES ___	NO ___
Have sudden loss of strength in arms or legs while awake? (induced by strong emotion)	YES ___	NO ___
Feel sleepy or fatigued during the day?	YES ___	NO ___
Have hyperactivity or is inattentive?	YES ___	NO ___
Had a previous sleep study?	YES ___	NO ___
If so, when and where (also, please attach prior test results)?		
How long does it typically take the patient to fall asleep?		
Usual Bedtime: _____ AM/PM Usual wake-up time: _____ AM/PM		

**MEDICAL HISTORY:** (Please also include office visit HISTORY & PHYSICAL)

- Allergies
- Large tonsil
- Deviated septum
- Gastroesophageal Reflux
- Allergies
- Large adenoids
- Nasal obstruction
- Craniofacial Malformation
- Obesity
- Previous T&A
- Enlarged Tongue
- Seizures
- Cardiac problems
- Nasal Polyps
- Small pharyngeal inlet
- Neuromuscular weakness
- Diabetes
- High Cholesterol
- Hypertension

Other Medical History/Allergies?: \_\_\_\_\_

Does the patient have a tracheostomy? Y/N If yes, during study should the tracheostomy be OPEN or CAPPED?

Does the patient use supplemental oxygen? Y/N If yes, should O2 be given during the test? Y/N How much? \_\_\_ L/min?

Does the patient use CPAP or BPAP? Y/N If yes, what mode, pressures, and mask size? \_\_\_\_\_

Date & type of serious surgery: \_\_\_\_\_

Special Needs: \_\_\_\_\_

WEIGHT: \_\_\_\_\_ lb. HEIGHT: \_\_\_\_\_ in. MEDICATIONS: \_\_\_\_\_

IAUTHORIZE USA SLEEP TO PEFORM SLEEP STUDIES ON ABOVE PATIENT ACCORDING TO THEIR PROTOCOLS, INCLUDING URGENT INITITATION OF O2 & CPAP.

PHYSICIAN (Print) \_\_\_\_\_ Signature: \_\_\_\_\_ DATE \_\_\_\_\_

SPECIALTY: \_\_\_\_\_ NPI # \_\_\_\_\_ Medicare # \_\_\_\_\_

PHONE# \_\_\_\_\_ FAX # \_\_\_\_\_

ADDRESS: \_\_\_\_\_