

# Texas Pulmonary Sleep Center – Sleep Study Referral & Prescription Form

*Thank you for referring your patient for a sleep study evaluation. In order to expedite patient acceptance and scheduling, we require this completed Rx form and the patient's insurance/contact information to be faxed to us at (817) 860-8772. For more information please call the office at (817) 461-8772. We appreciate your patience and cooperation!*

Referring MD: \_\_\_\_\_ NPI: \_\_\_\_\_ Nurse: \_\_\_\_\_

Office address to submit test results: \_\_\_\_\_

Office Ph #: \_\_\_\_\_ Fax #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Patient's name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Cell #: \_\_\_\_\_ Home ph#: \_\_\_\_\_ Work ph #: \_\_\_\_\_

**Do you request your patient to receive a sleep evaluation & consultation by one of our sleep specialists?**  YES  NO

\*Please note that patients who do not receive an evaluation by one of our sleep lab physicians must complete all the medical information section for patient acceptance criteria prior to scheduling. PSG results can only be reported to patients who receive consultations. Without a consultation – the results must be reported to the referring physician who will be responsible for notifying their patient of results and treatment plan.

**Suspected Diagnosis & ICD-9 Code (Check appropriate boxes):**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Obstructive Sleep Apnea (OSA) <u>327.23</u>    | <input type="checkbox"/> Hypersomnia with sleep apnea <u>780.53</u>    | <input type="checkbox"/> Hypersomnia <u>780.54</u>               |
| <input type="checkbox"/> Organic Sleep Apnea, unspecified <u>327.20</u> | <input type="checkbox"/> Narcolepsy without cataplexy <u>347.00</u>    | <input type="checkbox"/> Sleep Arousal Disorder <u>307.46</u>    |
| <input type="checkbox"/> Central Sleep Apnea <u>327.21</u>              | <input type="checkbox"/> Narcolepsy with cataplexy <u>347.01</u>       | <input type="checkbox"/> Parasomnia <u>327.40</u>                |
| <input type="checkbox"/> Unspecified Sleep Apnea <u>780.57</u>          | <input type="checkbox"/> Sleep Related Movement Disorder <u>780.58</u> | <input type="checkbox"/> Insomnia with Sleep Apnea <u>780.51</u> |
| <input type="checkbox"/> Other (specify with ICD-9 Code) _____          |  |  |

**Sleep History/Symptoms (Check appropriate boxes):**

- |  |  |   |                                     |
|--|--|---|-------------------------------------|
| <input type="checkbox"/> Excessive daytime sleepiness / fatigue          | <input type="checkbox"/> Muscle/joint aches          | <input type="checkbox"/> Limb jerks/twitches      | <input type="checkbox"/> Insomnia   |
| <input type="checkbox"/> Witnessed apneas / snoring                      | <input type="checkbox"/> Wakes up choking/gasping    | <input type="checkbox"/> Restlessness             | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Nightmares / night terrors                      | <input type="checkbox"/> Difficulty initiating sleep | <input type="checkbox"/> Sleep walking / talking  | <input type="checkbox"/> Dyspnea    |
| <input type="checkbox"/> Morning headaches                               | <input type="checkbox"/> Sleep paralysis (Cataplexy) | <input type="checkbox"/> Teeth grinding / bruxism |                                     |
| <input type="checkbox"/> s/p UA surgery for OSA (list procedures): _____ |  | Date: _____                                       |                                     |

**Relevant Medical History (Check appropriate boxes):**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Fibromyalgia      | <input type="checkbox"/> Stroke           | <input type="checkbox"/> Hiatal hernia   |
| <input type="checkbox"/> Pulmonary hypertension   | <input type="checkbox"/> Thyroid disorder  | <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> CHF             |
| <input type="checkbox"/> Pulmonary disease (COPD) | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Claustrophobia   | <input type="checkbox"/> Latex allergies |
| <input type="checkbox"/> Cardiac Arrhythmia       | <input type="checkbox"/> Hepatitis         | <input type="checkbox"/> Seizures         | <input type="checkbox"/> CAD             |
| <input type="checkbox"/> Other: _____             |  |   |  |

**Sleep Study Orders (Check appropriate box or leave for sleep specialist to determine after consultation):**

- All night PSG for diagnostic evaluation (95810)
- All night Titration PSG with Positive Airway Pressure (PAP) applied during study (95811) \*Documentation of OSA? \_\_\_Yes \_\_\_No
- Narcolepsy Screen (Overnight Polysomnography followed by daytime MSLT)
- Multiple Sleep Latency Test/MSLT or Maintenance of Wakefulness Test/MWT (95805) \*Circle procedure Name Ordered
- Overnight Pulse Oximetry Screening (94762)
- Supplemental O2 applied throughout testing (without meeting sleep lab O2 protocol). RX: O2 @ \_\_\_\_ lpm via NC or mask.
- Other: \_\_\_\_\_

If the patient has had a previous PSG, please include where, when & results: \_\_\_\_\_

Special Needs/Requirements (currently):  Oxygen  Wheelchair  Recliner  Bed Pads  Caretaker  Communication barriers

Ordering physician's signature: \_\_\_\_\_ Date ordered: \_\_\_\_\_

\_\_\_\_ Approved \_\_\_\_ Not approved Comments: \_\_\_\_\_

Clinical/Medical Director Signature: \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL INFORMATION**

**ORDERS**