

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

*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.

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**Suspected Diagnosis & ICD-9 Code (Check appropriate box of qualifying diagnosis code):**

- |   |  |  |
|---|--|--|
| <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"/> Other Organic Parasomnia <u>327.49</u>  |
| <input type="checkbox"/> Other & 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 Organic Sleep Apnea <u>327.29</u>        | <input type="checkbox"/> Morbid Obesity <u>278.01</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"/> Snoring    |
| <input type="checkbox"/> Witnessed apneas  | <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: _____             |  |   |  |

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**Sleep Study Orders (Check procedure or leave blank if ordering consultation with procedure):**

- 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
- Split Night PSG (Diagnostic evaluation + PAP Titration) \*AHI criteria: \_\_\_\_\_ with 4-hour minimum treatment duration allowed.
- PAP-Nap Sleep Study, Attended by respiratory specialist (95807)
- Narcolepsy Screen (Overnight Polysomnography followed by daytime Multiple Sleep Latency Test/MSLT)
- Maintenance of Wakefulness Test/MWT (95805) \*Please provide previous sleep studies.
- Actigraphy testing (95803) for minimum duration of 3 days – 14 days \*Please order duration: \_\_\_\_\_ days.
- Overnight Pulse Oximetry Screening (94762)
- Supplemental O2 at \_\_\_\_\_ liters per minute via NC/mask applied throughout testing (without meeting sleep lab O2 protocol).
- Portable Sleep Study, unattended (95806/G0399)\*Requires face to face pre-study comprehensive evaluation with sleep specialist.
- Other: \_\_\_\_\_

If the patient has had ANY previous PSG's, please attach and provide location, date, & 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 \_\_\_\_\_