Milford Regional Physician Group

*The Benchmark for Quality Care*

# Sleep Testing 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#______________

Insurance Provider: ________________________________________Insurance ID #: ________________________

**NOTE: PATIENT MUST BE 13 YEARS OR OLDER **

**SLEEP STUDY REQUESTED**

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

☐ **Split Night (95811):** Attended diagnostic 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 diagnostic testing. Recommended ONLY for patients with high likelihood of Obstructive Sleep Apnea (OSA).

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

**Select one:**

☐ I will follow up and treat. No consult ☐ Consult Lung, Allergy & Sleep Specialists

**SPECIAL NEEDS/ASSISTANCE** (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 (G47.52)
☐ 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)

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

**DOCUMENTED COMORBIDITIES & MEDICAL HISTORY**

☐ Critical illness or physical impairments preventing use of portal HST Device
☐ Moderate or severe Congestive Heart Failure
☐ History of myocardial infarction (s/p 3 mo.)
☐ History of Stroke DATE: _____________
☐ Moderate to severe pulmonary disease
☐ Polycythemia

☐ Patient prescribed opiates. Specify: ________________________________
☐ Neuromuscular weakness affecting respiratory function or impaired activity. Specify: ________________________________
☐ Other: ______________________________________________

**Duration of Symptoms:**

☐ < 2 months ☐ > 2 months ☐ > 6 months ☐ > 1 year

**Ordering Provider Signature:** ______________________________________ **Date:** __________________

**Printed Name:** ______________________________________________ **NPI:** __________________