



Physician Order

POLYSOMNOGRAPHY

For Diagnosis and Treatment of Sleep Disorders **DATE OF STUDY:** _____

TO SCHEDULE: 678-450-3625 THEN FAX TO: 678-450-3626 *Patient's insurance and demographic information, order for test, Epworth scale, Physician office notes with two Symptoms, medication and allergy list.*

Patient Information:

Legal Name (Last, First, MI): _____ DOB: _____
Address: _____
Home Phone: _____ Work Phone: _____ cell phone: _____

EPWORTH SCORE; _____ **HEIGHT:** _____ **WEIGHT:** _____

Procedure Orders:

- Polysomnography (PSG) First Night Study (with follow-up management) *
****If patient is denied in lab study, Home Sleep test with follow-up management.***
- CPAP Titration Second Night Study
- Bi-Level Titration Second Night Study
- PSG w/CPAP Titration Split Night Study
- Multiple Sleep Latency Test Day Study
- Sleep medicine consult with Physician

Preliminary Diagnosis:

- Excessive daytime sleepiness** (G47.69)
- Suspected sleep apnea, undefined** (G47.30)
- Sleep disturbance, unspecified** (G47.30)
- Insomnia** (G47.00) **Narcolepsy** (G47.419)

Clinical Symptoms: Insurance requires TWO documented in office visit notes

- Witnessed Apnea* *Loud Snoring*
- Gasping* *Fatigue*
- Choking*
- Excessive Daytime Sleepiness Epworth >10*

Previously Diagnosed:

- COPD* *Neuromuscular Disease*
- CHF* *Seizure Disorder*
- Atrial Fib* *Stroke*
- Obesity* *On O₂@ _____ /pm*

Special Needs:

Does patient have special needs? _____
Is the patient on oxygen? _____
Does the patient already use CPAP? _____

Ordering Physician Information:

Physician Name: _____ Phone: _____ Fax: _____

Ordering Physician's Signature: _____ **Date:** _____

Reviewing Physician Signature: _____ comments: _____