Florida Hospital Center for Sleep Disorders

Sleep Study Order Form

TREATMENT LOCATION

Check the location that is best for your patient, complete this form, and then fax it to the corresponding number below: Date:_____

❍ Orlando ❍ Altamonte ❍ Celebration ⇨ Fax this form to: **(407) 303-1567** Tel. (407) 303-1558

❍ East Orlando ❍ Winter Park ❍ Apopka ⇨ Fax this form to: **(407) 646-7161** Tel. (407) 646-7466

PATIENT INFORMATION

Note: An H&P or most recent office notes with complete medical condition is required by insurance. ***Please submit with this order.***

Name: _____ DOB: _____

Home phone: _____ Work/mobile phone: _____

Email: _____ SS#: _____ Gender: ❍ M ❍F

Address: _____

Insurance: _____ Auth Req?: ❍Yes or ❍No Auth #: _____ Subscriber: _____

DIAGNOSTIC TESTS & PROCEDURES

DIAGNOSIS

- ❑ 327.23 Obstructive Sleep Apnea
- ❑ 327.21 Central Sleep Apnea
- ❑ 333.94 Restless Legs Syndrome
- ❑ 347.00 Narcolepsy/EDS
- ❑ 327.40 Parasomnias
- ❑ 327.11 Idiopathic Hypersomnolence
- ❑ 327.42 REM Behavior Disorder
- ❑ Other diagnosis: _____

  _____

PRE-EXISTING CONDITION(S)

Note: It is important to indicate any of these pre-existing conditions

- ❑ Severe pulmonary disease (such as COPD, asthma)
- ❑ Neuromuscular disease (such as Parkinson's, prior stroke, ALS, Alzheimer's)
- ❑ Significant cardiac disease (such as CHF, arrhythmia, pulmonary hypertension)
- ❑ Obesity Hypoventilation Syndrome
- ❑ Obesity: List height _____ and weight _____
- ❑ Epworth Sleepiness Scale (ESS) = 10 or more

  If you need an ESS form, please call any of our sleep centers

REQUESTED PROCEDURE(S)

- ❑ Baseline Polysomnogram

  Note: An at-home test will be performed if a Baseline Polysomnogram is denied by insurance, or if an at-home test is requested by the primary care physician.
- ❑ CPAP/BiPAP titration
- ❑ Multiple Sleep Latency Test (MSLT)
- ❑ Sleep Specialist consultation
- ❑ Evaluation of OSA before discontinuing CPAP/BiPAP usage
- ❑ Evaluation of OSA after ENT surgery
- ❑ Other:_____

For pediatrics only:

- ❑ Full EEG pediatric sleep study

PHYSICIAN INFORMATION

Ordering Physician: _____ **Phone:** _____ **Fax:** _____

Physician signature: _____ **Office contact:** _____ ❍ Patient H&P or last office notes—***required by insurance***

By signing you are ensuring that the physician has seen the patient face-to-face and has notes on file that support the indicators selected above. For Medicare patients, you are attesting that the face-to-face evaluation met all applicable Medicare statutory and regulatory requirements.

Sleep Center Only—comments:

Attempts to contact patient:

1st _____ 2nd_____3rd_____