tri-valley SLEEP CENTER

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SLEEP EVALUATION REQUEST

Patient Name: FIRST _____ LAST _____

Date of Birth: _____ /_____ /_____ Phone: _____

_____ **Consult/Management –** Please evaluate and manage sleep issues prior to and/or post test(s).

_____ **Diagnostic, Comprehensive Polysomnography**

- Due to strict pre-authorization requirements, if requesting sleep study ONLY, please check the following if applicable:
  - R/O Periodic Limb Movement Disorder (ICD-10 G47.61)
  - R/O Central Sleep Apnea (ICD-10 G47.31)

_____ **CPAP/Bi-Level PAP/ASV/Oral Appliance Titration Polysomnogram**

_____ **Split Night Polysomnography** – Diagnostic portion followed by titration portion

_____ **Multiple Sleep Latency Test (MSLT)/Maintenance of Wakefulness Test (MWT) -** [Daytime Naps]

_____ **Home Sleep Test –** Take home sleep device to evaluate for sleep disordered breathing

PLEASE FAX THIS FORM TO *(925) 327-0300* WITH THE FOLLOWING:

1. **Copy of insurance card**
2. **Patient demographic information**
3. **Clinical notes related to sleep issues**

PRELIMINARY DIAGNOSIS CODES

_____ Sleep Apnea/Sleep Related Breathing Disorder, Unspecified (ICD-10 G47.30)
_____ Obstructive Sleep Apnea (ICD-10 G47.33) _____ Narcolepsy (ICD-10 G47.411/G47.419)
_____ Periodic Limb Movements (ICD-10 G47.61) Other: _____

Clinical presentation/symptoms/existing illnesses (notation not needed if clinical notes faxed):
_____

_____ Oxygen to be titrated as needed _____ Patient to self-administer own medicine

Other instructions: _____

ORDERING PROVIDER INFORMATION

Name: _____ NPI: _____
Phone: _____ Fax: _____

PROVIDER SIGNATURE: _____ Date: _____

I certify that to the best of my knowledge, this test and any interpretation is medically necessary in order to assist in the proper diagnosis and/or treatment for the above named patient.