Please fax a copy of the patient's most recent office visit notes with this form.

THE SLEEP DISORDER CENTER OF OLEAN GENERAL HOSPITAL

SLEEP STUDY ORDER FORM

Fax: 716-373-9302 PH: 716-373-9300

Must be filled out completely!

PATIENT INFORMATION

Patient: _____ DOB: _____ SS#: _____

Street: _____ City, State, Zip: _____

Home phone: _____ Work phone: _____

1. Insurance Information
   a. Primary Insurance: _____
      ID #: _____ Group #: _____
      Subscriber: Relationship to patient: _____
      Insurance Verification: Is testing covered? ☐Yes ☐No
      Allowable: _____ CoPay Amt: _____
      Referral needed? ☐No ☐Yes - Referral #: _____
      Pre-auth. needed? ☐No ☐Yes - Approval #: _____
   b. Secondary Insurance: _____
      ID #: _____ Group #: _____
      Subscriber: Relationship to patient: _____
      Insurance Verification: Is testing covered? ☐Yes ☐No
      Allowable: _____ CoPay Amt: _____
      Referral needed? ☐No ☐Yes - Referral #: _____
      Pre-auth. needed? ☐No ☐Yes - Approval #: _____

2. Tests ordered (please check): Note: if split night criteria are met CPAP titration will be initiated.
   ☐Overnight Polysomnography plus subsequent CPAP titration (if AHI is equal to or greater than 5) CPT 95810, CPT95811
   ☐CPAP titration
   ☐CPAP Repeat Titration Study - Current Settings: _____
   ☐BIPAP Study - Current Settings:
   ☐ASV
   ☐MWT Maintenance of wakefulness
   ☐(MSLT) Multiple Sleep Latency Test
   ☐Sleep consultation with Dr. Eric Tenbrock in Olean
   ☐Post-UPPP PSG Surgeon: _____
   ☐Post-oral device PSG Dentist: _____

   Diet: _____

Is patient on CPAP? ☐No ☐Yes (current setting): _____
Is the patient currently on continuous oxygen therapy? ☐No ☐Yes - LPM _____
If yes, may we initiate the study on room air and initiate 02 protocol if criteria are met? ☐No ☐Yes
Has the patient had a previous sleep study? ☐No ☐Yes - when: _____
Where: _____
If not at Olean General, please send copy of report along with this form if available.
What shift does the patient work? ☐Day ☐Evening ☐Night

3. Diagnosis:
   ☐Obstructive sleep apnea
   ☐Obesity hypoventilation syndrome
   ☐Periodic limb movement
   ☐S/P upper airway surgery
   ☐Other: _____
   ☐Insomnia
   ☐Sleep-related epilepsy
   ☐Narcolepsy
   ☐REM sleep behavior disorder

I, the undersigned, certify the above-prescribed procedure is medically necessary in the documentation and/or treatment of suspected diagnosis.

Physician Name (printed): _____ Signature: _____

Address: _____

Phone: _____ Fax: _____ Date: _____