



**REMSLEEP DIAGNOSTIC CENTER  
AT TEXAS STATE SLEEP LAB  
512-392-1442/ Fax 512-245-7990**



**SLEEP STUDY ORDER FORM**

Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M / F  
 Insured: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home: \_\_\_\_\_ Work: \_\_\_\_\_ Other: \_\_\_\_\_

**\*\*\* PLEASE SEND FAX COPIES OF PRIMARY AND SECONDARY INSURANCE INFORMATION \*\*\***

Sleep Test Orders

Diagnosis / CMN

- nPSG - Full night diagnostic study
- Split Night - 1/2 diagnostic, 1/2 night titration
- ↳ (Titration started per AASM standard)
- Initiate O<sub>2</sub> 1-4 lpm if SaO<sub>2</sub> < 89%

- 327.10\_Organic Hypersomnia Unspecified
- 780.50\_Sleep Disturbances
- 347.10\_Narcolepsy w/o cataplexy
- 347.11\_Narcolepsy w/ cataplexy

- nPSG with CPAP/BiPAP Full night titration

- 780.51\_Insomnia w/sleep apnea
- 780.53\_Hypersomnia w/sleep apnea
- 780.57\_Sleep Apnea Unspecified
- 327.23\_OSA Adult and Pediatric

- MSLT - Multiple sleep latency test
- MWT - Maintenance of wakefulness test

- 780.53\_Hypersomnia w/sleep apnea
- 347.10\_Narcolepsy w/o cataplexy
- 347.11\_Narcolepsy w/ cataplexy

Sleep History / Medical Necessity

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abnormal EKG      | <input type="checkbox"/> Impaired Cognition     | <input type="checkbox"/> Nocturia                           |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Ischemic Heart Disease | <input type="checkbox"/> Nocturnal Awakenings               |
| <input type="checkbox"/> Bruxism           | <input type="checkbox"/> Leg Cramps             | <input type="checkbox"/> Restless Legs                      |
| <input type="checkbox"/> COPD              | <input type="checkbox"/> Mood Disorders         | <input type="checkbox"/> Shortness of Breath Upon Awakening |
| <input type="checkbox"/> Hypersomnia       | <input type="checkbox"/> Morning Headaches      | <input type="checkbox"/> Snoring                            |
| <input type="checkbox"/> Hypertension      | <input type="checkbox"/> Night Sweats           | <input type="checkbox"/> Tonsils Absent                     |
| <input type="checkbox"/> Nasal Obstruction | <input type="checkbox"/> 1 naris                | <input type="checkbox"/> both nares                         |
|  |   | <input type="checkbox"/> Witnessed Apnea                    |

Other Symptoms: \_\_\_\_\_

Special needs/orders: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Interpreting physician?**

- NO PREFERENCE
  - YES \_\_\_\_\_
- PLEASE SPECIFY INTERPRETING PHYSICIAN

Physician Signature \_\_\_\_\_ Date: \_\_\_\_\_  
 Please Print Physician Name: \_\_\_\_\_ UPIN: \_\_\_\_\_  
 Clinic Location: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance List for SleepMed Diagnostic Center

Blue Cross Blue Shield ALL PLANS  
 Humana ALL PLANS  
 Medicare Advantage PPO

MediView (ARIA Network)  
 Physicians Health Choice Select  
 Physicians Health Choice Platinum

Medicare  
 Medicaid  
 Superior

CMS  
 PHCS  
 Tricare