Name: 
DOB: 
Age: 
Physician: 
Phone: 
Date: 

FOR USE BY CENTRAL SCHEDULING
Authorization for Study: ___________________________ Authorization Date Range: _____________

Stop Bang Score: _______ (0-2 low risk, 3-4 Intermediate risk, >5 high risk) (see Questionnaire on page 2)

Diagnosis
☐ Disrupted Sleep (G47.00)  ☐ Snoring (R06.83)  ☐ Dry Mouth (R06.5)  ☐ Morning Headaches (G44.1)
☐ SOB upon awakening (R06.02)  ☐ Hypertension (I10)  ☐ OSA (G47.10)  ☐ Other _________________

PATIENT MEDICAL HISTORY
☐ Hypertension (CM I10)  ☐ Type I Diabetes (CM E10.9)
☐ COPD (CM J44.9)  ☐ Type II Diabetes (CM E11.9)
☐ Stroke (CM I63.50)  ☐ Headaches (CM R51)
☐ Heart Disease (CM I51.9)  ☐ Depression (F33)
☐ CHF (CM I50.9)  ☐ Other _________________

TYPE OF STUDY BEING ORDERED
☐ Attended Split night – If AASM criteria are met, I authorize the CPAP Titration the same night. (If pre-authorization is required, will need authorization for both PSG 95810 and Titration 95811)
☐ PSG (95810) – Diagnostic required prior to titration study
☐ Titration Study (95811)
☐ MSLT or MWT (95805)
☐ Home Sleep Apnea Test (95800)

SCAN AND EMAIL SLEEP STUDY REFERRAL FORM (pages 1 & 2), H&P AND FACE SHEET TO THE ADDRESS:
<csioptimizationteam@R1RCM.com>

Physician Signature: ___________________________ Date: ___________________________ 

NPI: ___________________________
**STOP-BANG Sleep Apnea Questionnaire**

<table>
<thead>
<tr>
<th>STOP</th>
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</thead>
<tbody>
<tr>
<td>Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you often feel TIRED, fatigued, or sleepy during daytime?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Has anyone OBSERVED you stop breathing during your sleep?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you have or are you being treated for high blood PRESSURE?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>BANG</th>
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<tbody>
<tr>
<td>BMI more than 35kg/m2?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>AGE over 50 years old?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>NECK circumference &gt; 16 inches (40cm)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>GENDER: Male?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**SCORE**

- **High risk of OSA:** (Yes 5 - 8)
- **Intermediate risk of OSA:** (Yes 3 - 4)
- **Low risk of OSA:** (Yes 0 - 2)