Heywood Medical Group
Member of the Heywood Healthcare Family

Heywood Pulmonology
242 Green Street, Gardner, MA 01440 / 978-630-5011 / Fax 978-630-5023

A. Patient Information

Patient Name: _____ DOB: _____ Sex: _____

Address: _____ City: _____ State: _____

Phone (Home): _____ Work : _____ Cell: _____

Email: _____

Insurance Co.: _____ Policy No: _____ Group No: _____

Secondary Insurance Co: _____ Policy No: _____ Group No: _____

B.___ INITIAL CONSULT WITH SLEEP SPECIALIST AND SUBSEQUENT CLINICAL MANAGEMENT

Refer for initial consult for possible sleep disorder to include necessary diagnostic sleep studies and subsequent therapy including positive airway pressure (PAP) and clinical management if indicated. **Skip to section D**

Clinical follow up preference:
Joseph Walek, MD ___ Sweta Desai, MD ___

C.___ DIRECT REFERRAL SLEEP TESTING

All sections required. Ordering provider is responsible for follow up and treatment unless requested otherwise.

**** PLEASE NOTE PRIOR AUTHORIZATIONS WILL BE OBTAINED THROUGH REFERRING PROVIDER***

1. DIAGNOSIS: _____ **G47.33 Obstructive Sleep Apnea (adult/pediatric)**

2. EPWORTH: _____ HEIGHT: _____ WEIGHT: _____ BMI: _____ FeV1/FVC: _____ Fev1: _____

3. SLEEP TEST ORDERED: _____ **HST - Unattended OSA Recording 95806/G0399**

Interpreter preference:
Joseph Walek, MD: _____ Sweta Desai, MD _____

Prior Authorization number: _____ **Dates effective:** _____

D. REFERRING PROVIDER SIGNATURE

Physician Signature: _____ Date: _____

NP/PA/RN Signature: _____ Date: _____

Printed Name: _____ Phone: _____ Fax: _____

Address: _____ Office Contact: _____

PATIENT CLINICAL DATA-REQUIRED FOR PRE-AUTHORIZATION
(NOT REQUIRED IF REFERRING PATIENT FOR A SLEEP CONSULTATION)
COMPLETE ALL SECTIONS CHECK ALL THAT APPLY

Patient Name: _____ **DOB:** _____

Height: _____ Weight: _____ BMI: _____ Shift Worker: _____ Symptoms interfere with ADLs: _____
Cognitive Impairment (inability to follow simple instructions will interfere with Home Sleep Study Instructions: _____

A. CURRENT REPORTED PATIENT COMPLAINTS:
____ Disruptive snoring ____ Excessive Daytime Sleepiness ____ Disturbed or Restless sleep ____ Non restorative sleep
____ Unable to tolerate current PAP pressure ____ Fatigue ____ Irritability/moodiness ____ Patient awakens gasping for breath
____ Inability to fall asleep

Complaint duration: _____ <one month _____ >one month _____ > three months _____ > six months

B. SIGNS AND SYMPTOMS:
____ Witnessed apnea events, chocking or gasping ____ Frequent unexplained arousals ____ Non-ambulatory individual
____ Nocturia ____ Morning headaches ____ Restless or jerking legs ____ Suspected cataplexy ____ Frequent prolonged daily naps

Complaint duration: ____ <one month ____ >one month ____>three months ____ >six months
Assessment of hypersomnolence: ____ Impairment of job performance ____ Impairment of safety ____ Impairment of driving
Is the FEV1/FVC </= to 0.7? ____ Yes ____ No FEV1 <80% of predicted: _____

C. CO-MORBID CONDITIONS (Recent office note is required):
____ Unexplained pulmonary hypertension ____ Uncontrolled COPD/Lung Disease ____ Uncontrolled CHF (Class III or IV)
____ Uncontrolled significant, persistent cardiac arrhythmia ____ Suspected Nocturnal Seizures
____ Neuromuscular weakness and impaired respiratory function ____ Diabetes ____ Nocturnal Desaturation

Co-Morbid Duration: ____ <one month ____ >one month ____ <three months ____ >six months

D. NON-OSA SUSPECTED SLEEP DISORDER:
____ Complex sleep Disordered Breathing ____ Suspected REM behavior disorder ____ Suspected Narcolepsy
____ Periodic Leg Movements (Periodic Limb Movement Disorder) ____ Restless Leg Syndrome ____ Suspected Parasomnia
____ Central Sleep Apnea ____ Circadian Rhythm Disorder ____ Idiopathic Hypersomnia

E. REPEAT SLEEP STUDY:
Is this a repeat sleep study?: ____ YES ____ NO
If YES complete the following: Where was a previous Sleep Study completed? _____
(Please fax us the Technical Report and Interpretation of previous Sleep Study)

IF PATIENT IS ON PAP THERAPY ARE YOU ABLE TO FAX THE MOST RECENT COMPLIANCE REPORT THAT WAS AT LEAST 2 MONTHS OF RECORDED DATA? ____ YES ____ NO

IF NO CAN THE PATIENT REPORT: ____ PAP used > 2 months
____ PAP Therapy > 4 hours/night for at least 70% of nights

IF PATIENT CANNOT REPORT ABOVE INFORMATION, PLEASE STATE WHY PATIENT HASN NOT BEEN COMPLIANT WITH PAP THERAPY: _____

F. EPWORTH SLEEPINESS SCALE
This is required for all pre-authorizations.