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LEOMINSTER SLEEP CENTER 100 Erdman Way Ste. 2S

Phone: 978-728-4641 Fax: 978-798-1382



WORCESTER SLEEP CENTER

85 Prescott St Ste. 302 Phone: 774-420-2611 Fax: 774-420-2616

A PATIENT INFORMATION Patient Name:							
Address:	A. PATIENT INFOR	MATION					
Address:	Patient Name:			SSN:	DC	B:	
City:							
Phone (Home):							
Insurance Co:Policy No:::							
Secondary Insurance: Policy: Group No: INITIAL CONSULT WITH SLEEP SPECIALIST AND SUBSEQUENT CLINICAL MANAGEMENT: Refer for initial consult to MLA Sleep Specialist for possible sleep disorder to include necessary diagnostic sleep studies and subsequent therapy including positive aniway pressure (PAP) and clinical management if indicated. Skip to section D OR: Clinical follow-up preference: LEDME Preyn Aglaszi, MO Iwas Acase: MO Orders Conserved Molecular Base and MLA Clinical and agement if indicated material molecular and management if indicated material molecular and management if indicated material molecular and management if indicated material molecular and material molecul							
□ INITIAL CONSULT WITH SLEEP SPECIALIST AND SUBSEQUENT CLINICAL MANAGEMENT: Refer for Initial consult to MLA Sleep Speciality 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 OR: Clinical follow-up preference: LEDEL Payer Aghate, MD marketer, MD Subsequent, MD States Alexacy, MD Preference: Proference: DIRECT REFERRAL FOR SLEEP TESTING: All sections required. Ordering provider is responsible for follow- up and there there are indexed otherwise. The Direct Reference indexed and MLA Clinical Data form is required. 1. DIAGNOSIS: Please check Primary and all Co-Morbid Diagnosis that apply to this referral G47.30 Obstructive sleep apnea (adult/pediatric) G47.61 Periodic Limb Movement Disorder G47.30 Complex Sleep Apnea G47.50 Parasonnia, unspecified G47.50 Parasonnia, unspecified G47.50 Parasonnia, unspecified G47.9 Sleep Related Hyperventilation/Hypoxemia G47.30 Central Sleep Apnea G47.31 Central Sleep Apnea C.EPWORTH: HEIGHT: WEIGHT BMI: FeV1/FVC: FeV1: 3. SLEEP TEST ONDEREDI 9580/ G0399 ASV Titration 95811 G47.30 Parasonia, unspecified G47.31 Central Sleep Apnea 2. EPWORTH: HEIGHT: WEIGHT BMI: FeV1/FVC: FeV1:							
C. DIRECT REFERRAL FOR SLEEP TESTING: All sections required. Ordering provider is responsible for follow- up and treatment unless requested otherwise. "PLASE NOTE PEDRA AUTHORIZATIONS WILL BE OBTAINED THROUGH MLA SLEEP CENTER**** However your list office note and MLA Clinical Data form is required 1. DIAGNOSIS: Please check Primary and all Co-Morbid Diagnosis that apply to this referral G47.33 Obstructive sleep apnea (adult/pediatric) G47.31 Complex Sleep Apnea G47.35 Sleep Related Hyperventilation/Hypoxemia G47.30 Unspecified Sleep Apnea G47.35 Sleep Related Hyperventilation/Hypoxemia G47.30 Unspecified Sleep Apnea G47.35 Sleep Related Hyperventilation/Hypoxemia G47.30 Unspecified G47.50 Parasomnia, unspecified G47.30 Unspecified G47.50 Parasomnia, unspecified G47.31 Complex Sleep Apnea G47.32 REM Sleep Related Movement Disorder G47.419 Hypersomnia, unspecified G47.31 Central Sleep Related Seizure Disorder G47.419 Nacolepsy G47.31 Central Sleep Apnea C.EPWORTH: HEIGHT: WEIGHT: BMI: FeV1/FVC: FeV1: SLEEP TEST ORDERED: G58104 G47.31 Central Sleep Apnea G47.5511 GPAP TIRATION ONLY S5811 GPAP TIRATION ONL	MANAGEMENT: Re studies and subsequent the OR:	fer for <u>initial consult to MLA</u> erapy including positive airv	Sleep Specia way pressure (Clinical	list for possible sleep of PAP) and clinical man	lisorder to include necessary agement if indicated. Skip to	section D	
G47.33 Obstructive sleep apnea G47.61 Periodic Limb Movement Disorder G47.31 Complex Sleep Apnea G47.69 Sleep Related Movement Disorder G47.36 Sleep Related Hyperventilation/Hypoxemia G47.50 Parasomnia, unspecified G47.30 Unspecified Sleep Apnea G47.52 REM Sleep Behavior Disorder G47.30 Unspecified Sleep Apnea G47.52 REM Sleep Behavior Disorder G47.30 Unspecified Sleep Apnea G47.52 REM Sleep Behavior Disorder G47.10 Hypersonnia, unspecified G47.31 Contral Sleep Apnea G47.19 Nacolepsy G47.31 Central Sleep Apnea 2. EPWORTH: HEIGHT: WEIGHT: BMI: FeV1/FVC: FeV1: 3. SLEEP TEST ORDERED: G47.52 REM Sleep Apnea G47.31 Contral Sleep Apnea G47.31 Contral Sleep Apnea PSG if not approved HST permissible 95806/ G0399 ASV Titration 95811 GPLVSOMNOGRAM ONLY 95810 G47.41 NiGHT STUDY 95811 GPLAP TITRATION ONLY 95811 GeG/MULTIPLE SLEEP LATENCY TEST (MSLT) 95810 & 95805 Special Requests: TcCO2 ETCO2(dx only) Date/Location of previous sleep study		ERRAL FOR SLEEF	P TESTING	All sections required	. Ordering provider is respons DBTAINED THROUGH MLA SLI	ble for follow- up and	
G47.35 Obstitutive steep Apnea G47.69 Steep Related Movement Disorder G47.36 Steep Related Hyperventilation/Hypoxemia G47.50 Parasomnia, unspecified G47.30 Unspecified Steep Apnea G47.52 REM Steep Behavior Disorder G47.30 Unspecified Steep Apnea G47.52 REM Steep Behavior Disorder G47.31 Complex Steep disturbance, unspecified G47.31 Central Steep Apnea G47.419 Nacolepsy G47.31 Central Steep Apnea 2. EPWORTH: HEIGHT: WEIGHT: BMI: FeV1/FVC: FeV1: 3. SLEEP TEST ORDERED: G47.52 REM Steep Apnea G47.31 Central Steep Apnea PSG if not approved HST permissible 95810/95086 G0399 ASV Titration 95811 G27.95 Gif not approved HST permissible 95810/95086 G0399 Medicare Oxygen Titration on PAP 95811 G26/MULTIPLE SLEEP LATENCY TEST (MSLT) 95810 & 95805 Special Requests: TcCO2 ETCO2(dx only) Date/Location of G47.10 NONLY 95811 Special Requests: TcCO2 ETCO2(dx only) Date/Location of previous sleep study	1. DIAGNOSIS: Plea	se check Primary and all	Co-Morbid D	iagnosis that apply to	this referral		
3. SLEEP TEST ORDERED:	 G47.31 Complex Sleep Apnea G47.36 Sleep Related Hyperventilation/Hypoxemia G47.30 Unspecified Sleep Apnea G47.10 Hypersomnia, unspecified G47.9 Sleep disturbance, unspecified 			 G47.69 Sleep Related Movement Disorder G47.50 Parasomnia, unspecified G47.52 REM Sleep Behavior Disorder G40.919 Sleep Related Seizure Disorder G47.8 Dysfunctions associated with Sleep Stages or Arousal from Sleep 			
HST- Unattended OSA Recording 95806/ G0399 ASV Titration 95811 POLYSOMNOGRAM ONLY 95810 (Left Ventricular Ejection Fraction:) TcCO2 Monitoring) Medicare Oxygen Titration on PAP 95811 SPLIT NIGHT STUDY 95811 CPAP TITRATION ONLY 95811 BiLevel TITRATION ONLY 95811 EXTENDED EEG (Phase 95813 Delay: Late Sleeper) Interpreter preference: Image: Payam Aghassi, MD Inna Ketsler, MD J. REFERRING PHYSICIAN/RN SIGNATURE Date: Physician Signature: Phone: Printed Name: Phone:	2. EPWORTH:	HEIGHT:	WEIGHT:	BMI:	FeV1/FVC:	FeV1:	
POLYSOMNOGRAM ONLY 95810 PSG if not approved HST permissible 95810/95086 G0399 (Otherwise Physician agrees to peer to peer with this order) 95811 SPLIT NIGHT STUDY 95811 CPAP TITRATION ONLY 95811 BiLevel TITRATION ONLY 95811 BiLevel TITRATION ONLY 95813 Delay: Late Sleeper) Interpreter preference: LEOM: Payam Aghassi, MD Inna Ketsler, MD Joseph Walek, MD Odatys Croteau, MD Word: Musicare Albakour, Mt Philip Burke, MD Steven Devis, MD Isteria Sailer, MD	3. SLEEP TEST OR	DERED:					
	POLYSOMNOGRAM O PSG if not approved HS (Otherwise Physician ag SPLIT NIGHT STUDY CPAP TITRATION ONL BiLevel TITRATION ON EXTENDED EEG (Phase)	NLY 95810 T permissible 95810/95086 grees to peer to peer with this o 95811 LY 95811 ILY 95811	G0399	(Left Ventricular Eject Medicare Oxygen Titr PSG/MULTIPLE SLE PSG/MAINTENANCE Special Requests: To	ation on PAP EP LATENCY TEST (MSLT) E OF WAKEFULNESS TEST CO2 ETCO2(dx only) Date	Monitoring 95811 95810 & 95805 95810 & 95805 5/Location of	
PHYSICIAN SIGNATURE: Date: NURSE PRACTITIONER/RN SIGNATURE: Date: Printed Name: Phone: Fax:	LEOM : Payam Aghassi, MD	Inna Ketsler, MD Joseph Walek, I	Interpre	ter preference: au, MD <u>WORC:</u> Mustafa Albak	our, MD_Philip Burke, MD _Steven Davis	s, MD Stacia Sailer, MD	
Printed Name: Fax: Fax: Fax: Office Contact:	PHYSICIAN SIGNATURE: NURSE PRACTITIONER/RN SIGNATURE:				Date: Date:		
	Printed Name:			_ Phone:	Fax: Office Contact:		



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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 or breath _____ Inability to fall asleep

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

B. SIGNS AND SYMPTOMS:

_____ Witnessed apnea events, choking or gasping _____ Frequent unexplained arousals _____Nonambulatory individual _____ Nocturia _____ Morning Headaches _____ Restless or jerking legs _____ Suspected cataplexy _____ Frequent prolonged daily naps

Symptom 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. <u>CO-MORBID CONDITIONS (Recent office note is required):</u>

_____ 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

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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. <u>REPEAT SLEEP STUDY</u>

IS THIS A REPEAT SLEEP STUDY: _____YES ____NO IF YES COMPLETE THE FOLLOWING: Was a previous Sleep Study completed at MLA Sleep Center? ____YES ____NO IF the Sleep Study was completed at another facility are you able to fax us the Technical Report and Interpretation? IF NO Name of Facility: _____

IF PATIENT IS ON PAP THERAPY ARE YOU ABLE TO FAX THE MOST RECENT COMPLIANCE REPORT THAT HAS 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 NOT COMPLIANT WITH PAP THERAPY: _____

F. EPWORTH SLEEPINEES SCALE

This is required for all prequthorizations. Please see the scoring sheet that follows