

**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: \_\_\_\_\_ S

**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, choking 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  $\leq$  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.