☐ **LEOMINSTER SLEEP CENTER**
100 Erdman Way Ste. 2S
Phone: 978-728-4641 Fax: 978-798-1382

MLA | MASS LUNG & ALLERGY PC

☐ **WORCESTER SLEEP CENTER**
85 Prescott St Ste. 302
Phone: 774-420-2611 Fax: 774-420-2616

A. PATIENT INFORMATION

Patient Name:_____ SSN:_____ DOB:_____

Address:_____ Apt:_____ Sex:_____

City:_____ State:_____ Zip Code:_____

Phone (Home):_____ Work:_____ Cell:_____ E-Mail:_____

Insurance Co:_____ Policy No.::_____ Group 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 airway pressure (PAP) and clinical management if indicated. **Skip to section D**

OR:

Clinical follow-up preference:

LEOM: ☐ *Payam Aghassi, MD* ☐ *Inna Ketsler, MD* ☑ *Joseph Walek, MD* ☐ *Odalys Croteau, MD* WORC: ☐ *Mustafa Albakour, MD* ☐ *Philip Burke, MD* ☐ *Steven Davis, MD* ☐ *Stacia Sailer, MD*

C. ☐ DIRECT REFERRAL FOR 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 MLA SLEEP CENTER*****

However your last 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
- ☐ G47.36 Sleep Related Hyperventilation/Hypoxemia
- ☐ G47.30 Unspecified Sleep Apnea
- ☐ G47.10 Hypersomnia, unspecified
- ☐ G47.9 Sleep disturbance, unspecified
- ☐ G47.419 Nacolepsy
- ☐ G47.61 Periodic Limb Movement Disorder
- ☐ 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
- ☐ G47.31 Central Sleep Apnea

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

3. SLEEP TEST ORDERED:

- ☐ HST- Unattended OSA Recording 95806/ G0399
- ☐ POLYSOMNOGRAM ONLY 95810
- ☐ PSG if not approved HST permissible 95810/95086 G0399
  (Otherwise Physician agrees to peer to peer with this order)
- ☐ SPLIT NIGHT STUDY 95811
- ☐ CPAP TITRATION ONLY 95811
- ☐ BiLevel TITRATION ONLY 95811
- ☐ EXTENDED EEG (Phase Delay: Late Sleeper) 95813
- ☐ ASV Titration 95811
  (Left Ventricular Ejection Fraction:_____) TcCO2 Monitoring_____
- ☐ Medicare Oxygen Titration on PAP 95811
- ☐ PSG/MULTIPLE SLEEP LATENCY TEST (MSLT) 95810 & 95805
- ☐ PSG/MAINTENANCE OF WAKEFULNESS TEST 95810 & 95805

Special Requests: TcCO2 ETCO2(dx only) Date/Location of previous sleep study_____

Interpreter preference:

LEOM: ☐ *Payam Aghassi, MD* ☐ *Inna Ketsler, MD* ☑ *Joseph Walek, MD* ☐ *Odalys Croteau, MD* WORC: ☐ *Mustafa Albakour, MD* ☐ *Philip Burke, MD* ☐ *Steven Davis, MD* ☐ *Stacia Sailer, MD*

D. REFERRING PHYSICIAN/RN SIGNATURE

PHYSICIAN SIGNATURE:_____ **Date:**_____

NURSE PRACTITIONER/RN SIGNATURE:_____ **Date:**_____

Printed Name:_____ Phone:_____ Fax:_____

Address:_____ Office Contact:_____

MLA | MASS LUNG & ALLERGY PC

SLEEP CENTER

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

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 ___Non-ambulatory 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. 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

MLA | MASS LUNG & ALLERGY PC

SLEEP CENTER

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

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: 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