

MLA

MASS LUNG
&
ALLERGY
PC

SLEEP CENTER, Leominster Campus 100 Erdman Way, Leominster, MA 01453

Phone: 978-728-4641

Fax: 978-978-1382

MEDICAL DIRECTOR: Payam Aghassi, MD, FCCP

Thank you for your sleep study order!

Attached please find our order form for sleep studies and consults.

Please insure that these forms are completely filled out. We need the referral form signed, dated along with your printed name. Unless you are requesting a consult with MLA, we also require that a specific sleep study is selected. We will have to fax back incomplete orders

**Thank you,
Scheduling and Administrative Staff
Mass Lung & Allergy Sleep Centers**

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

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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

- | | |
|---|--|
| <input type="checkbox"/> G47.33 Obstructive sleep apnea (adult/pediatric) | <input type="checkbox"/> G47.61 Periodic Limb Movement Disorder |
| <input type="checkbox"/> G47.31 Complex Sleep Apnea | <input type="checkbox"/> G47.69 Sleep Related Movement Disorder |
| <input type="checkbox"/> G47.36 Sleep Related Hyperventilation/Hypoxemia | <input type="checkbox"/> G47.50 Parasomnia, unspecified |
| <input type="checkbox"/> G47.30 Unspecified Sleep Apnea | <input type="checkbox"/> G47.52 REM Sleep Behavior Disorder |
| <input type="checkbox"/> G47.10 Hypersomnia, unspecified | <input type="checkbox"/> G40.919 Sleep Related Seizure Disorder |
| <input type="checkbox"/> G47.9 Sleep disturbance, unspecified | <input type="checkbox"/> G47.8 Dysfunctions associated with Sleep Stages or Arousal from Sleep |
| <input type="checkbox"/> G47.419 Nacolepsy | <input type="checkbox"/> G47.31 Central Sleep Apnea |

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

3. SLEEP TEST ORDERED:

- | | |
|---|--|
| <input type="checkbox"/> HST- Unattended OSA Recording 95806/ G0399 | <input type="checkbox"/> ASV Titration 95811 |
| <input type="checkbox"/> POLYSOMNOGRAM ONLY 95810 | (Left Ventricular Ejection Fraction: _____) TcCO2 Monitoring _____ |
| <input type="checkbox"/> PSG if not approved HST permissible 95810/95086 G0399
(Otherwise Physician agrees to peer to peer with this order) | <input type="checkbox"/> Medicare Oxygen Titration on PAP 95811 |
| <input type="checkbox"/> SPLIT NIGHT STUDY 95811 | <input type="checkbox"/> PSG/MULTIPLE SLEEP LATENCY TEST (MSLT) 95810 & 95805 |
| <input type="checkbox"/> CPAP TITRATION ONLY 95811 | <input type="checkbox"/> PSG/MAINTENANCE OF WAKEFULNESS TEST 95810 & 95805 |
| <input type="checkbox"/> BiLevel TITRATION ONLY 95811 | Special Requests: TcCO2 ETCO2(dx only) Date/Location of
previous sleep study _____ |
| <input type="checkbox"/> EXTENDED EEG (Phase
Delay: Late Sleeper) 95813 | |

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: _____



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Epworth Sleepiness Scale (REQUIRED FOR ALL PRE-AUTHORIZATIONS)

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness.

Use the following scale to choose the most appropriate number for each situation:

- 0 = would *never* doze or sleep.
- 1 = *slight* chance of dozing or sleeping
- 2 = *moderate* chance of dozing or sleeping
- 3 = *high* chance of dozing or sleeping

Situation	
-----------	--

Sitting and reading _____

Watching TV _____

Sitting inactive in a public place _____

Being a passenger in a motor vehicle for an hour or more _____

Lying down in the afternoon _____

Sitting and talking to someone _____

Sitting quietly after lunch (no alcohol) _____

Stopped for a few minutes in traffic while driving _____

Total score (add the scores up) _____
(This is your Epworth score)



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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 ___ 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 \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



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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. 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 SLEEPINESS SCALE

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