

ADULT SLEEP CENTER PRESCRIPTION

Ordering a Sleep Study at Premier Sleep Centers is easy. Follow steps 1-3 to complete the Physician Prescription Referral Form

<p>1 Indications/Clinical Observations <i>Please check all that apply</i></p> <ul style="list-style-type: none"> <input type="radio"/> Snoring <input type="radio"/> Witnessed Apnea <input type="radio"/> Restless Sleep <input type="radio"/> Excessive Daytime Sleepiness (or Daytime Fatigue) <input type="radio"/> Obesity <input type="radio"/> Abnormal Behavior During Sleep <input type="radio"/> Morning Headaches <input type="radio"/> Shift Work <input type="radio"/> Sleep Paralysis <input type="radio"/> Cataplexy <input type="radio"/> Drowsy Driving 	<p>2 Diagnosis Suspected <i>Please check one</i></p> <ul style="list-style-type: none"> <input type="radio"/> Obstructive Sleep Apnea (OSA) <input type="radio"/> Periodic Limb Movement (PLM) <input type="radio"/> Narcolepsy <input type="radio"/> Upper Airway Resistance Syndrome <input type="radio"/> Nocturnal Seizure <input type="radio"/> Parasomnia <input type="radio"/> REM Behavior Disorder <input type="radio"/> Hypersomnia NOS <input type="radio"/> Hypersomnia w/OSA 	<p>3 Services Requested <i>Please check all that apply</i></p> <ul style="list-style-type: none"> <input type="radio"/> Initial sleep physician consultation; studies to be ordered as appropriate <input type="radio"/> Polysomnogram (PSG) 95810 <input type="radio"/> PSG with MSLT 95810,95805 <input type="radio"/> PSG with MWT 95810,95805 <input type="radio"/> Bi – Level Titration 95811 <input type="radio"/> CPAP/Bi-level titration 95811 <input type="radio"/> CPAP / Re-titration 95811 <input type="radio"/> DME set up <input type="radio"/> Split Night Study 95811 <input type="radio"/> Oral Appliances <input type="radio"/> I do not want a sleep physician consultation (a sleep consult and appropriate follow-up will occur on all patients unless otherwise indicated).
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Patient Name: _____ Patient DOB: _____

Parent/Guardian (If under 18) _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Other: _____

Special Instructions / Pertinent Medical History: _____

PHYSICIAN SIGNATURE (REQUIRED)

PHYSICIAN NAME (PRINTED)

DATE

PHONE

FAX

I authorize Premier Sleep Centers to perform services on the above patient according to clinical protocols approved by the medical director.

