

Education
and
Diagnostic Services

In-take Sheet - Patient Information

Date of Birth _____ SSN of Patient: _____

Patient's Name: _____

Patient's Address: _____

Home #: _____ Work #: _____ Cell #: _____

Primary Insurance Co: _____ Ins. Phone _____

Ins. Mailing Address: _____

Ins. ID #: _____ Name of Policy Holder
if Different from Patient: _____

Secondary Ins. Co: _____

Referring Physician: _____

NPI#: _____ UPIN#: _____

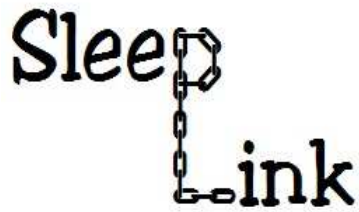
Dr.'s Phone #: _____ Dr. Fax #: _____

Name of person who called in order: _____ Nurse: _____

Dr.'s Address: _____

Has this patient had a sleep study done before? _____
If not done at SleepLink: When? _____ Where? _____

SleepLink SouthWest
Phone: 806-888-1115 Fax: 806-888-1117



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PRESCRIPTION FORM

Patient Name

Height/Weight

Date of birth

*Diagnosis: _____

*Condition: _____

Test Prescribed:

_____ **Polysomnogram (PSG):** Up to 16 channels of recording, lasting 6 to 8 hours.
DIAGNOSTIC STUDY ONLY! (CPT Code 95810)

_____ **CPAP Titration Study:** Patient has undergone a previous sleep apnea study and has met the criteria for CPAP titration. (CPT Code 95811)

_____ **SPLIT NIGHT STUDY:** A combination of a diagnostic PSG and CPAP titration. Patient must meet the following criteria: 30 apneas lasting 10 seconds or longer during the first 3 hours of sleep. Patient must be able to maintain a steady state of sleep during this time. CPAP Titration cannot be performed on patients that are awake. (CPT Code 95811)

_____ **MSLT (Multiple Sleep Latency Test):** This is a DAYTIME test consisting of a series of 20 minute naps every 2 hours. This test is used in the diagnosis of narcolepsy and also as a standard measure of sleepiness. MSLT must be preceded by an overnight PSG. (CPT Code 95805)

_____ **Oxygen** can be initiated and titrated during the test if indicated by a drop in oxygen saturation.

Medical Necessity Form: Please explain how the patient's overall condition necessitates this study being done:

Physician's Printed Name: _____

Physician's Signature: _____ Date: _____

Address: _____

Telephone: _____ UPIN #: _____

NPI #: _____

Signature of Physician certifies that the above represents his/her judgment of the patient's need for the study.

Fax Completed Forms to: 806-888-1117
SleepLink SouthWest – phone: 806-888-1115