



REQUISITION FORM FOR SLEEP STUDY SERVICES

STUDY SITE:

GUAM SLEEP CENTER

PIA MARINE, 193 TUMON LANE, #609, TAMUNING, GU 96913

SCHEDULING: PHONE: (671) 64SNOOZ (647-6669) FAX: (671) 647NAPS (647-6277)

PATIENT INFORMATION:

Name: _____ Date of Birth: ____/____/____

Address: _____ E-mail Address: _____

Home Phone: _____ Business: _____ Cell: _____

INSURANCE INFORMATION: **Please check with insurance carrier to obtain authorization if applicable.**

Insurance Carrier: _____ Member#: _____ Auth#: _____

REFERRING PHYSICIAN: _____ SPECIALTY: _____ Phone: _____

Fax: _____ Contact Person: _____ Cc: Physician: _____

TYPE OF SERVICE REQUESTED: Please check at least one box before submitting.

- Video-Polysomnogram (PSG) Baseline (Diagnostic overnight sleep test from 7:30 p.m. to 6:00 a.m.) 95810
Multiple Sleep Latency Test MSLT (Diagnostic daytime nap study, 7:00 a.m. to 5:00 p.m.) 95805
Continuous Positive Airway Pressure - CPAP titration (Treatment titration night from 7:30 p.m. to 6:00 a.m.) 95811
Video-Polysomnogram/CPAP titration Split-Night (Diagnostic overnight sleep test/titration from 7:30 p.m. to 6:00 a.m.) 95811
Initial evaluation for sleep pathology
Follow-up visit
CPAP/BiPAP device and interface dispensing

SUSPECTED SLEEP DIAGNOSIS: [] Obstructive Sleep Apnea [] Other: _____

Duration of Symptoms: _____ Medial Hx: _____

Ambulatory Patient: Yes No Requires Personal Assistance: Yes No Requires Oxygen at ____ lpm

PLEASE CHECK ALL THAT APPLY:

- Apnea Observed, Snoring, Gasping at night, Deviated septum, Small Oropharynx, Enlarged tonsils, Enlarged tongue, Short/thick neck, Retrognathia / Micrognathia, Malimpatti Class 1 2 3 4
Obesity, Recent Weight Gain/Loss __ lbs, Cardiac Arrhythmias, Hypertension, Heart Failure, Asthma/Bronchitis COPD, Difficulties with current CPAP/BiPAP
Headache during morning hours, Fatigue, Excessive Daytime Somnolence, Impaired intellectual functioning, Declining social functioning, Restless Legs/Periodic Limb Movements during sleep
Post Stroke, Narcolepsy/Cataplexy, Sleepwalking (somnambulism), Unusual or violent nocturnal movement, Nocturnal Seizure, Teethgrinding (Bruxism)
Insomnia, Depression, Anxiety, CHILDREN (2 Years+), Failure to grow, ADHD, Craniofacial Abnormalities or Genetic Syndrome

Table with 7 columns: Age, Wt, Ht, BP, Pulse, Male or Female, Adult or Child

Referring physician's signature: _____

Reviewed by Sleep Specialist: Gabriele M. Barthlen, M.D.