GUAM SLEEP CENTER

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ACCREDITED MEMBER CENTER

REQUISITION FORM FOR SLEEP STUDY SERVICES

PATIENT INFORMATION. ***Please Print.***

NAME *(LAST, FIRST, M.I.)* _____ DATE OF BIRTH *(MM/DD/YY)* ____/____/____

Address _____ E-mail Address _____

Home Phone_____ Business _____ Cell_____

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

Carrier _____ Member# _____ Auth# _____

REFERRING PHYSICIAN _____ **SPECIALTY** _____

Phone _____ Fax _____ Contact Person _____ Cc: Physician _____

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

☐ 1. **Baseline** Video-Polysomnogram (PSG) (Diagnostic overnight sleep test, from 7:30 p.m. to 6:00 a.m.).....CPT **95810**
☐ 2. **CPAP titration** Continuous Positive Airway Pressure (Treatment titration night, from 7:30 p.m. to 6:00 a.m.).....CPT **95811**
☐ 3. **Split-Night** (Combined diagnostic sleep test/CPAP titration, from 8:00 p.m. to 6:00 a.m.).....CPT **95811**
☐ 4. **MSLT** Multiple Sleep Latency Test (Daytime nap study, 7:00 a.m. to 5:00 p.m. to r/o narcolepsy).....CPT **95805**
☐ 5. **Initial evaluation for sleep pathology**

SUSPECTED SLEEP DIAGNOSIS: ☐ **Obstructive Sleep Apnea** ☐ **Other:** _____

Duration of Symptoms _____ **Medical Hx** _____

_____

Ambulatory Patient	**Requires Personal Assistance**	**Requires Oxygen**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes, at _____ lpm ☐ No

PLEASE CHECK ALL THAT APPLY.

- ☐ Apnea Observed
- ☐ Snoring
- ☐ Gasping at night
- ☐ Deviated septum
- ☐ Small Oropharynx
- ☐ Enlarged tonsils
- ☐ Enlarged tongue
- ☐ Short/thick neck
- ☐ Retrognathia / Micrognathnia
- ☐ Mallampati Class 1 2 3 4
- ☐ Obesity
- ☐ Recent Weight **Gain** _____ lbs
- ☐ Recent Weight **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
- ☐ Sleepwalking (somnambulism)
- ☐ Teeth-grinding (Bruxism)
- ☐ Unusual or violent nocturnal movement
- ☐ Nocturnal Seizure
- ☐ Post Stroke
- ☐ Narcolepsy/Cataplexy
- ☐ Insomnia
- ☐ Depression
- ☐ Anxiety

CHILDREN (2 Years+)

- ☐ Failure to grow
- ☐ ADHD
- ☐ Craniofacial Abnormalities or Genetic Syndrome

Age	**Weight**	**Height**	**Temp**	**BP**	**Pulse**	☐ **Male** ☐ **Female**	☐ **Adult** ☐ **Child**

Referring Physician's Signature: _____

Reviewed by ABMS Board Certified Sleep Specialist: ***Gabriele M. Barthlen, M.D., Ph.D.*** _____