GUAM SLEEP CENTER

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ACCREDITED MEMBER CENTER

REQUISITION FORM FOR SLEEP STUDY SERVICES

PATIENT INFORMATION. *Please Print Clearly.* TODAY'S DATE_____

NAME *(LAST, FIRST, M.I.)* _____ DOB *(MM/DD/YYYY)* _____

MAILING ADDRESS _____ E-MAIL _____

HOME PHONE _____ BUSINESS _____ MOBILE _____

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

CARRIER _____ MBR# _____ AUTH# _____

REFERRING PHYSICIAN _____ SPECIALTY _____

CLINIC _____ PHONE _____ FAX _____ POC _____

CC: (Physician & Address)_____

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

- ☐ CPT **95810**: **Baseline** Diagnostic Video-Polysomnogram (PSG), overnight sleep test
- ☐ CPT **95811**: **Titration** Treatment w/ Continuous and/or Bi-level Positive Airway Pressure (☐CPAP / ☐BiPAP), overnight
- ☐ CPT **95811**: **Split-Night** Combined Baseline and Titration, overnight
- ☐ CPT **95805**: **Multiple Sleep Latency Test** (MSLT), daytime nap study (r/o narcolepsy)
- ☐ CPT **95782**: **Pediatric Baseline** Diagnostic video-PSG for pediatric patients 2-5 years old, overnight sleep test
- ☐ CPT **95783**: **Pediatric Titration** Treatment titration with CPAP/BiPAP for pediatric patients 2-5 years old, overnight
- ☐ **Initial evaluation for sleep pathology**

PERTINENT ADDITIONAL INFORMATION.

SUSPECTED SLEEP DIAGNOSIS: ☐OBSTRUCTIVE SLEEP APNEA ☐OTHER _____

DURATION OF SYMPTOMS _____ MEDICAL HX_____

AMBULATORY PATIENT?	REQUIRES PERSONAL ASSISTANCE?	REQUIRES OXYGEN?
☐Y ☐N	☐Y ☐N	☐Y, at ____ lpm ☐N

PLEASE CHECK ALL THAT APPLY

- ☐Apnea Observed
- ☐Snoring
- ☐Gasping at night
- ☐Choking
- ☐Deviated Septum
- ☐Small Oropharynx
- ☐Enlarged Tonsils
- ☐Enlarged Tongue
- ☐Short/Thick Neck
- ☐Retrognathia
- ☐Micrognathia
- ☐Mallampati Class 1, 2 , 3 , 4
- ☐Obesity
- ☐Recent Weight **Gain** ____ lbs
- ☐Recent Weight **Loss** ____ lbs
- ☐Metabolic Syndrome
- ☐Cardiac Arrhythmias
- ☐Hypertension
- ☐Heart Failure
- ☐Asthma / Bronchitis
- ☐COPD
- ☐Difficulty w/current PAP Mach.
- ☐Diabetes
- ☐Hypercholesterolemia
- ☐Morning Headaches
- ☐Fatigue
- ☐Excessive Daytime Somnolence
- ☐Impaired intellectual functioning
- ☐Declining social functioning
- ☐Restless Legs
- ☐Periodic Limb Mvmnts in Sleep
- ☐Sleepwalking (Somnambulism)
- ☐Teeth-grinding (Bruxism)
- ☐Unusual/violent nocturnal mvmnt
- ☐Nocturnal Seizure
- ☐Post-Stroke
- ☐Narcolepsy/Cataplexy
- ☐Insomnia
- ☐Non-restorative Sleep
- ☐Fragmented Sleep
- ☐Depression
- ☐Anxiety
- ☐Failure to Grow (*Children*)
- ☐ADHD (*Children*)
- ☐Craniofacial Abnormality
- ☐Genetic Syndrome

AGE	**WEIGHT** (lbs)	**HEIGHT** (in)	**TEMP**	**BP**	**PULSE**	☐MALE ☐FEMALE	☐ADULT ☐CHILD

Referring Physician's Signature: _____

Reviewed by ABMS Board Certified Sleep Specialist: _____