# -SLEEP STUDY INTAKE FORM-

## Fax To: 888-765-6615

| Patient Information | Insurance Information |
|---|---|
| Patient Name: | Insurance Company: |
| Contact Home Phone: | I.D. # |
| Contact Work/Cell Phone: | Insurance Phone: |
| Address: | Insured Name: |
| City/State/Zip: | PCP: |
| DOB: Sex: M / F | PCP Tel # |

| Facility Information | |
|---|---|
| Facility Name | Facility Code: |

**VERIFICATION OF MEDICAL NECESSITY:**

| TYPE OF STUDY REQUESTED: | PATIENT REFERRED FOR EVALUATION OF: |
|---|---|
| _____Nocturnal Polysomnogram (NPSG) 95810 | _____Obstructive Sleep Apnea 327.23 ___RLS/PLMD 327.51 |
| _____CPAP titration for OSA [no ETCO2] 95811 | _____Central Sleep Apnea 327.3 ___Narcolepsy 347 |
| _____BPAP titration for OSA [no ETCO2] 95811 | _____Hypoventilation 327.26 ___Parasomnias 327.40 |
| _____BPAP titration for hypoventilation [with ETCO2] 95811 | _____Unexplained drowsiness 327.10 ___Insomnia 327.00 |
| _____Split night study (NPSG/CPAP if AHI >=20) | _____Unspec. Sleep Disturbance 780.50 |
| _____Multiple sleep Latency Test (MSLT) 95805 | _____Post-operative evaluation:_____Other:_____ |
| _____Home Sleep Study Unattended (HST) 95806 | _____Simultaneous recording of heart rate, oxygen saturation, respiratory airflow and respiratory effort |
| _____Insomnia 95827 | _____Electroencephalogram (EEG) all night recording |

**Reason for Referral:**

_____

_____

**Special Instructions:**

_____

**Progress Notes: (*Progress notes of the patient's condition is to be attached)***

**History:**

_____

_____

_____

_____

******(OFFICE USE ONLY) ******

**MEDICAL DIRECTOR REVIEW:_____"By Signing you are attesting you have seen this patient face-to face and have patient notes on file that support the indicators selected above. For Medicare patients you are attesting the face to face evaluation met all applicable Medicare statutory and regulatory requirements."**

_____

## STOP BANG Questionnaire

**Height_____inches/cm Weight_____lb/kg**
**Age_____**
**Male/Female**
**BMI_____**
**Collar size of shirt S, M, L, XL, or _____inches/cm**
**Neck circumference*_____cm**

**1. Snoring**
**Do you snore loudly (louder than talking or loud enough to be heard through closed doors?)**
**Yes___ No__**

**2. Tired**
**Do you often feel tired, fatigued, or sleepy during daytime?**
**Yes___ No__**

**3. Observed**
**Has anyone observed you stop breathing during your sleep?**
**Yes___ No__**

**4. Blood pressure**
**Do you have or are you being treated for high blood pressure?**
**Yes___ No__**

**5. BMI**
**BMI more than 35 kg/m?**
**Yes___ No__**

**6. Age**
**Age over 50 yr old?**
**Yes___ No__**

**7. Neck circumference**
**Neck circumference greater than 40 cm?**
**Yes___ No__**

**8. Gender**
**Gender male?**
**Yes___ No__**

***Neck circumference is measured by staff**
***High risk of OSA:* answering yes to three or more items**
***Low risk of OSA:* answering yes to less than three items**

**Adapted from:**
***STOP* Questionnaire**
**A Tool to Screen Patients for Obstructive Sleep Apnea**
**Frances Chung, F.R.C.P.C.; Balaji Yegneswaran, M.B.B.S.; Pu Liao, M.D.; Sharon A. Chung, Ph.D.; Santhira Vairavanathan, M.B.B.S.; Sazzadul Islam, M.Sc.; Ali Khajehdehi, M.D.; Colin M. Shapiro, F.R.C.P.C.**

**SLEEP HISTORY: Does, or has, the patient:**

| | | |
|---|---|---|
| **Often wake up with a morning headache?** | **YES__** | **NO__** |
| **Snore regularly/excessively during sleep?** | **YES__** | **NO__** |
| **Been observed to have pauses inbreathing pattern during sleep?** | **YES__** | **NO__** |
| **Awaken with gasping, choking, dry mouth or throat?** | **YES__** | **NO__** |
| **Tend to be a mouth breather?** | **YES__** | **NO__** |
| **Experience a restless sensation in arms or legs during sleep or in the evening?** | **YES__** | **NO__** |
| **Been told that they make kicking movements during sleep?** | **YES__** | **NO__** |
| **Have difficult)' falling asleep at the beginning of the night?** | **YES__** | **NO__** |
| **Have difficulty staying awake during the day?** | **YES__** | **NO__** |
| **Have sudden loss of strength in arms or legs while awake? (induced by strong emotion)** | **YES__** | **NO__** |
| **Feel sleepy or fatigued during the day?** | **YES__** | **NO__** |
| **Have hyperactivity or is inattentive?** | **YES__** | **NO__** |
| **Had a previous sleep study?** | **YES__** | **NO__** |
| **If so, when and where (also, please attach prior test results)?** | | |
| **How long does it typically take the patient to fall asleep?** | | |
| **Usual Bedtime:_____AM/PM Usual wake-up time: _____AM/PM** | | |

**MEDICAL HISTORY: (Please also include office visit HISTORY & PHYSICAL)**

| | | | |
|---|---|---|---|
| **__Allergies** | **__Large tonsil** | **__Deviated septum** | **__Gastroesophageal Reflux** |
| **__Allergies** | **__Large adenoids** | **__Nasal obstruction** | **__Craniofacial Malformation** |
| **__Obesity** | **__Previous T&A** | **__Enlarged Tongue** | **__Seizures** |
| **__Cardiac problems** | **__Nasal Polyps** | **__Small pharyngeal inlet** | **__Neuromuscular weakness** |
| **__Diabetes** | **__High Cholesterol** | **__Hypertension** | |

**Other Medical History/Allergies?: _____**
**Does the patient have a tracheostomy? Y/N If yes, during study should the tracheostomy be OPEN or CAPPED?**
**Does the patient use supplemental oxygen? Y/N If yes, should 02 be given during the test? Y/N How much?____L/min?**
**Does the patient use CPAP or BPAP? Y/N If yes, what mode, pressures, and mask size?_____**
**Date & type of serious surgery: _____**
**Special Needs: _____**

**WEIGHT: _____lb. HEIGHT:___in. MEDICATIONS:_____**

**I AUTHORIZE USA SLEEP TO PEFORM SLEEP STUDIES ON ABOVE PATIENT ACCORDING TO THEIR PROTOCOLS, INCLUDING URGENT INITITATION OF O2 & CPAP.**

**PHYSICIAN (Print)_____Signature:_____ DATE _____**

**SPECIALTY:_____ NPI # _____ Medicare #_____**

**PHONE #_____FAX #_____**

**ADDRESS:_____**