Please complete and fax this form to: PinnacleHealth Sleep Center **(717) 920-4323** with current patient demographics, Insurance card copy and history/progress notes. Please call **(717) 920-4325** if you have any questions.

PERSONAL INFORMATION

Name: ______________________________ Birthdate: ______________ Gender: _____

Height: _______ Weight: ________ BMI: ________ Neck Circumference: _______ Appointment Date: _______________

STUDY TYPE (check one)	CPT CODE	DESCRIPTION
☐ Polysomnogram (PSG)*	95810	First night Diagnostic study for Evaluation only
☐ CPAP/BiPAP Titration*	95811	Titration study if PSG was positive for OSA
☐ CPAP/BiPAP Re-titration*	95811	Re-titration for previously diagnosed patients only
☐ Split-Night PSG*	95811	Initial Diagnostic period followed by CPAP if indicated
☐ MSLT	95805	Daytime study for EDS (PSG performed preceding night)
☐ MWT	95805	Maintenance of Wakefulness test
☐ Home Sleep Test	95806/G0399	2 Night diagnostic test for evaluation performed at home
☐ Other	________	

Presumptive Diagnosis: Please check all that apply.

- ☐ Sleep Apnea, Unspecified (780.53)
- ☐ Obstructive Sleep Apnea (327.23)
- ☐ Sleep hypoventilation / hypoxemia (327.26)
- ☐ Insomnia (307.42)
- ☐ Narcolepsy (347.00)
- ☐ Hypersomnia (327.10)
- ☐ Maintaining Wakefulness Disorder (307.44)
- ☐ Loud Snoring (786.09)
- ☐ Shift Work Disorder (327.36)
- ☐ Sleep Walking (307.46)
- ☐ Periodic Limb Movement Disorder (327.51)
- ☐ Restless Legs Syndrome (333.94)
- ☐ Morbid Obesity (278.01)
- ☐ Other (please specify): ____

Medical Conditions

- ☐ Cardiac Arrhythmias
- ☐ CHF
- ☐ Stroke
- ☐ Asthma/COPD
- ☐ Depression
- ☐ Crowded Oropharynx/Hypopharynx
- ☐ Neuromuscular Disorder (please specify): ______________________________
- ☐ Seizures
- ☐ GERD
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Thyroid Dysfunction
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Stent
- ☐ Hypertension
- ☐ Obesity
- ☐ Cerebral Palsy
- ☐ Cranial/Facial Abnormalities

Please specify _____________
____
____

Special Needs

- ☐ Nocturnal O2 Level ________________
- ☐ Interpreter, Language ______________
- ☐ Incontinence Problems
- ☐ Wheelchair/Assistance Walking
- ☐ Guardian, Parent, Custodian
- ☐ Tape, Latex, or Talc Allergy
- ☐ Other ________________________________

MEDICATIONS:

____
____

Ordering Physician: ______________________ (signature) ______________________ (printed name) ________ (date) ________ (time)

Sleep Center Director: ______________________ (signature) ______________________ (printed name) ________ (date) ________ (time)

PATIENT INFORMATION

Form 0035-07 (01/13) MR
InD