SLEEP ORDER FORM: *Fax to 866-454-5013*

Telephone: 855-633-6818

SHORE MEDICAL CENTER℠

710 Centre Street, Somers Point, NJ 08244 | Tel: 855-633-6818 | Fax: 866-454-5013

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ BMI: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ ID#: _____ Group #: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you ever been diagnosed with Obstructive Sleep Apnea? ☐ Yes ☐ No

If yes, when_____

Are you currently using PAP therapy? ☐ Yes ☐ No

If yes, settings _____

Are you currently under the care of a Pulmonologist? ☐ Yes ☐ No

If so, physician name_____

Epworth Sleepiness Scale

0 would NEVER doze | **1** SLIGHT chance of dozing | **2** MODERATE chance of dozing | **3** HIGH chance of dozing

Use the following scale to choose the most appropriate number for each situation

Sitting and Reading	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting, inactive in a public place such as a theater or meeting	**0**	**1**	**2**	**3**
As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**
Lying down to rest in the afternoon when circumstances permit	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**
Sitting quietly after a lunch without alcohol	**0**	**1**	**2**	**3**
In a car, while stopping for a few minutes in traffic	**0**	**1**	**2**	**3**

0-5 Lower Daytime Sleepiness/6-10 Higher Normal Daytime Sleepiness/11-12 Mild Excessive Daytime Sleepiness
/13-15 Moderate Excessive Daytime Sleepiness /16-24 Severe Excessive Daytime Sleepiness****

Score _____

****At risk for an underlying sleep disorder**

SLEEP STUDY REFERRAL:

☐ Split study per protocol* (95810/95811) if study positive or additional testing needed, schedule recommended titration study (CPAP, BiPAP, or ASV, 95811)

☐ Home Sleep Study (HSAT) 95806/G0399

☐ CPAP study (95811)

*HSAT if insurance denies in lab (95806/G0399)

SUSPECTED DIAGNOSIS

☐ Unspecified OSA (G47.30) ☐ OSA - previously diagnosed (G47.33) ☐ Other: _____

REFERRING PHYSICIAN

Physician Name:_____**Phone:**_____**Fax:**_____

Address:_____**Date:**_____**Time**_____

Doctor Name/Signature: _____

Letter of Medical Necessity

The symptoms indicated above are consistent with the presence of a sleep disorder which could possibly be life threatening. These findings may warrant the medical necessity of an overnight polysomnographic evaluation to assess the presence and severity of a sleep disorder.