



Sleep Study Order Form

Phone: (512) 697-9896

Fax: (512) 697-9895

5929 Balcones Drive

Suite 305 Austin, TX 78731

www.thesleepcenteraustin.com

Patient Name: _____ DOB: _____ Contact Phone#: _____

Please also provide patient's demographics, insurance information, pertinent medical history and any recent sleep studies.

SLEEP HISTORY & PRESENTING SYMPTOMS (check all that apply)

- Snoring
- Witnessed Apnea
- Morning Headaches
- Nocturia
- Daytime Sleepiness / Fatigue
- Other Symptoms: _____
- Nocturnal Awakenings
- Impaired Cognition
- Diabetes
- Insomnia
- Non Restorative Sleep
- Bruxism
- Restless Leg/Periodic Limb Movements
- Central Sleep Apnea
- Stroke
- Hypertension
- Obesity (BMI: _____)
- CHF

SERVICES REQUESTED

CONSULTATION AND MANAGEMENT

Initial consultation with Board Certified Sleep physician followed by appropriate testing, treatment, and ongoing sleep disorder management.

SLEEP STUDY ONLY (please select study orders and diagnosis below)

Once the study is completed, our office will send the results to the ordering physician for follow-up with the patient.

INTERPRETING PHYSICIAN:

Dr.Desai

Other _____

(Must be board certified in sleep)

POST TESTING CONSULT

Review of results with the patient at a consultation appointment after the study, initiation of treatment and on-going management by a Board Certified Sleep physician.

SLEEP STUDY ORDER (1 or more may apply)

- Perform HST if in-lab study is denied by insurance
- NPSG – overnight sleep study
- HST – home sleep study (1 or 2 night)
- CPAP Titration Study
- MSLT – multiple sleep latency test
- Split NIGHT
- Other: _____

SUSPECTED DIAGNOSIS

- R/O Sleep Apnea G47.33
- Treat OSA G47.33
- Treat CSA G47.31
- Treat Complex SA G47.31
- Re-Titration for OSA G47.33
- R/O PLMS G47.61
- R/O Narcolepsy G47.419
- Restless Leg Syndrome G25.81
- Other: _____

ARRANGE CPAP / BIPAP THERAPY

After consultation with referring physician

Referring Physician Name: _____

NPI: _____

Office Phone #: _____

FAX: _____

Physician Signature: _____

Date: _____

FAX RECENT CLINIC NOTE AND COMPLETED FORM TO: (512) 697-9895