

SLEEP STUDY REQUEST FORM
PH: 888-497-5337 ext. 121 FX: 866-217-2053



The following Sleep Study Request form must be completed for all sleep testing procedures.

Patient name:		DOB:	
Insurance plan: MVP.Health.Care		Member ID #:	
Patient address:		City, state, zip:	
Home Phone #:	Cell Phone	Work Phone #:	
Epworth Sleepiness Score *Required* (see worksheet):		BMI:	or Height:
			Weight:
Ordering Physician:		MD Signature (Required)	
Physician address:		City, state, zip:	
Physician Phone #:		Physician fax #:	

I. Study Requested: Is this a repeat study request: YES NO

If a 95810 is requested, but only a G0399 approved, may the G0399 home study be substituted? YES NO

- G 0399 (95806, G0398) Home Sleep Test 95810 (95807/8) Polysomnography – Attended
 95811 Polysomnography – Attended with initiation of Therapy 95805 Multiple Sleep Latency Testing

Participating Site if a Facility Based Study is authorized:

1. Name _____ TIN _____ 2. Name: _____ TIN _____

II. Clinical Information (check all that apply) (For Repeat Studies complete A, B, C for new onset symptoms):

A. Complaint(s):

- Disruptive snoring Excessive daytime sleepiness Disturbed or restless sleep Non-restorative sleep

B. Signs and Symptom(s): Witnessed apnea events, choking or gasping Frequent unexplained arousals
 Non-ambulatory individual Nocturia

C. Symptom Duration: < one month ≥ one month ≥ three months ≥ six months

D. Co-morbid conditions (Recent supporting office notes required):

- Unexplained Pulm hypertension Uncontrolled COPD/Lung Disease Uncontrolled CHF (Class III or IV)
 Uncontrolled significant, persistent cardiac arrhythmia Suspected Nocturnal seizures
 Neuromuscular weakness and impaired respiratory function CMPLX SDB
 Neurodegenerative Disorders/Cognitive Impairment preventing HST Suspected narcolepsy
 Disruptive sleep behavior suspicious of REM disorder or other (specify) _____

CoMorbDx Duration: < one month ≥ one month ≥ three months ≥ six months

E. Medications and Miscellaneous: SSRI Pain Control or Sedating medications Pt is night shift worker

F. Repeat Study Indication: Change in BMI >5 Recent T/A or UPP New Symptoms Other _____

G. PAP Compliance for Repeat Studies: PAP used > 2 months YES NO
PAP therapy 4+ hours on 70% of nights YES NO

DEFINITIONS: HST = home sleep study; NPSG = in lab polysomnogram; EDS = excessive daytime sleepiness; ESS = Epworth Sleepiness Scale; BMI = body mass index; CHF = congestive heart failure; COPD = Chronic Obstructive Pulmonary Disease; CMPLX SDB = Complex Sleep Disordered Breathing; CAH = Central Alveolar Hypoventilation; MSLT = multiple sleep latency test; MWT = maintenance of wakefulness test; SSRI = Selective Serotonin Reuptake Inhibitor; T/A = Tonsillectomy/Adenoidectomy; UPP = Uvulopalatoplasty



EPWORTH SLEEPINESS SCALE

MUST BE COMPLETED FOR AUTHORIZATION

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

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

- 0 = would never doze or sleep
- 1 = slight chance of dozing or sleeping
- 2 = moderate chance of dozing or sleeping
- 3 = high chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping	Scale
Sitting and reading		
Watching TV		
Sitting inactive in a public place		
Being a passenger in a motor vehicle for an hour or more		
Lying down in the afternoon		
Sitting and talking to someone		
Sitting quietly after lunch (no alcohol)		
Stopped for a few minutes in traffic while driving		

Total score equals your ESS	
-----------------------------	--

0 – 9 Average score, normal population

Physician's signature _____ **Date** _____