EMORY
SLEEP CENTER

REQUEST FOR SERVICES

FAX to 404-712-8145
PHONE: 404-712-7533
Emory Sleep Center •
12 Executive Park Dr NE, 4th floor • Atlanta, GA 30329

Patient Name _____

D.O.B. _____/_____/_____ Height & Weight **OR** BMI_____ Preferred Patient Phone #: (_____)_____

REQUESTING PROVIDER PHONE AND FAX:_____

REQUESTING PROVIDER (printed):_____ (signature):_____ date _____

LAB STUDY and/or OFFICE VISIT OPTIONS:

☐ **Overnight Sleep Diagnostic Study 1st, followed by Clinic Visit w/ Sleep Doctor for results**

If Lab study denied due to insurance (check choice below)

☐ Proceed with Home Sleep Test --- **OR** ---- ☐ Notify me for peer to peer

☐ **Clinic Visit w/ Sleep Doctor**

☐ **Overnight Sleep Study Only** (follow up with ordering physician)

STUDY TYPE:_____

☐ **Home Sleep Test** (please indicate if follow up preference is with Sleep or Referring doc: _____)

HISTORY & PHYSICAL EXAM NOTES DOCUMENTING SPECIFIC SLEEP COMPLAINTS MUST BE IN EMORY EMR OR FAXED WITH ORDER (Required for scheduling)

Sleep Specialist Review:
Date: Initials:
Comments:

DIAGNOSIS, HISTORY and SYMPTOMS for study: It is critical we have this information for authorizing test and showing medical necessity. Most recent office note should reflect this rationale and be available.

Diagnosis

- ☐ **Obstructive Sleep Apnea (G47.33)**
- ☐ **Unspecified Sleep Apnea (G47.30)**
- ☐ **Central Sleep Apnea (G47.31)**
- ☐ **Hypoventilation Syndromes (G47.36)**
- ☐ **Narcolepsy (G47.41)**
- ☐ **Hypersomnia (G47.10)**
- ☐ Parasomnias (G47.50)
- ☐ Periodic Limb Movement (G47.61)
- ☐ Restless Leg Syndrome (G47.62)
- ☐ Insomnia (G47.00)*** (absent other suspected diagnoses refer to clinic)

Past Medical History

- ☐ Sleep Apnea
- ☐ Current CPAP Use
- ☐ Prior CPAP Use
- ☐ Hypertension
- ☐ Cardiac Disease History
- ☐ Stroke
- ☐ Pulmonary Hypertension
- ☐ Nocturnal oxygen desaturation or cardiac arrhythmias during sleep
- ☐ Obesity BMI >30 Kg/m2 _____
- ☐ Parkinson's Disease

Symptoms (check all that apply)

- ☐ Witnessed apneas during sleep
- ☐ Epworth > 10 (Score: _____)
- ☐ STOP-Bang > 3 (Score: _____)
- ☐ Awakens with choking or gasping
- ☐ Persistent snoring
- ☐ Daytime sleepiness
- ☐ MVC, sleeping while driving
- ☐ Hallucination (type:_____)
- ☐ Sleep paralysis
- ☐ Narcolepsy w/cataplexy or w/o
- ☐ Violent sleep behavior
- ☐ Periodic limb movements

SPECIAL NEEDS AND INSTRUCTIONS:

- ☐ Study should be performed on oxygen; liter flow: _____
- ☐ Patient should wear dental appliance for study
- ☐ Allergies: ☐ Tape ☐ Latex ☐ Talc
- ☐ Medication Adverse Reaction: _____
- ☐ Patient uses walker, wheelchair, requires assistance for mobility
- ☐ Incontinence
- ☐ Interpreter required:
- ☐ Significant cognitive impairment:

Office Use: