

POLYSOMNOGRAPHY ORDER FORM

Patient's Name: _____ Date: _____

Patient Phone Number: Home: _____ Work: _____ Cell: _____

DOB: _____ Type of Insurance: _____ ID #: _____

Clinical Information: _____

(Please fax to REM a copy of patient's insurance information, including card, patient demographics, and any pertinent medical records such as previous PSG, oximetry report, H&P, consultations, etc. We will contact the patient for an appointment, then notify your office of the patient's appointment date by fax. If you have any questions, please contact our office.)

(Please check below)

- _____ Polysomnogram (done as a split-night format if criteria met) CPT 95811
- _____ CPAP/BiPAP titration - full night (usually as a follow up to a positive study) CPT 95811
- _____ Multiple sleep latency testing for narcolepsy (requires polysomnogram prior) CPT 95805
- _____ Servo-Ventilation (for central/complex sleep apnea-requires previous sleep study) CPT 95811

ICD9 CODES

Primary Codes (Check at least one)

Secondary Codes (Check all that apply)

- _____ 780.51 Insomnia with Sleep Apnea, diagnosed
- _____ 780.53 Hypersomnia with sleep apnea, diagnosed
- _____ 780.57 Obstructive sleep apnea, diagnosed
- _____ 780.54 Hypersomnia, unspecified
- _____ 780.56 Dysfunction associated with sleep stages or arousal from sleep
- _____ 780.58 Sleep related movement disorder
- _____ 780.59 Other sleep disturbances
- _____ 347.0 Narcolepsy, diagnosed
- _____ 307.42 Persistent disorder of initiating & maintaining sleep
- _____ 307.44 Persistent disorder of initiating & maintaining wakefulness
- _____ 327.24 Idiopathic sleep related nonobstructive alveolar hyperventilation (sleep related hypoxia)
- _____ 327.21 Primary central sleep apnea, diagnosed
- _____ 333.94 Restless leg syndrome, diagnosed
- _____ Other (specify) _____

- _____ 786.09 Snoring, respiratory insufficiency
- _____ 799.02 Hypoxemia
- _____ 278.01 Morbid obesity
- _____ 401.1 Hypertension, benign
- _____ 780.79 Fatigue/malaise
- _____ 496 COPD
- _____ 429.2 Cardiovascular disease, unspecified
- _____ 414.05 Coronary artery disease
- _____ 428.0 Congestive heart failure
- _____ Other (specify) _____

Physician's Name: _____

Phone: _____ Fax: _____

Physician's Signature: _____

(Must be signed to be a legal prescription)

Mailing Address:

SAN LUIS OBISPO FACILITY:
1329 Broad Street, Suite C
San Luis Obispo, CA 93401

PHONE: (805) 785-0126
FAX: (805) 785-0127

PASO ROBLES FACILITY:
1145 Vine Street
Paso Robles, CA 93446