JOINT COMMISSION ACCREDITED

REM Diagnostics, Inc.

Specialists in Sleep Diagnostics

POLYSOMNOGRAPHY & CONSULTATION ORDER FORM

Patient's Name: _____ Date: _____

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

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

Please fax to REM Diagnostics 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, progress reports, 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 specific test below)

_____ **Standard Sleep Study** (done as a split-night format if criteria met) CPT 95810/95811

_____ **CPAP/BiPAP titration**- full night (usually as a follow up to a positive study) CPT 95811

_____ **Adaptive Servo-Ventilation Titration** (for central/complex sleep apnea-requires previous sleep study) CPT 95811

_____ **Multiple Sleep Latency Testing** for narcolepsy (requires polysomnogram prior) CPT 95805

_____ **Home Sleep Test** (for qualifying patients) CPT 95805

The providers at Central Coast Chest Consultants are available to assist you in the evaluation and management of sleep apnea.

_____ Please schedule a visit with Central Coast Chest Consultants prior to the sleep study to further evaluate for sleep disorders and to educate the patient in advance about the clinical significance and pathophysiology of sleep apnea, what to expect during the sleep study and potential treatment options.

_____ Please schedule a follow up appointment at Central Coast Chest Consultants for further evaluation and sleep management subsequent to the sleep study.

The above referenced patient has an absolute medical necessity for the procedure(s) listed above, based on my preliminary diagnosis. I certify that the above prescribed procedure(s) is/are medically indicated, reasonable and necessary with reference to the standards of medical practice and treatment of the patient's condition.

Physician's Name: _____

Phone: _____ Fax: _____

Physician's Signature: _____

(Must be signed by physician to be a legal prescription)

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

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

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