HSD Sleep Center

"The Path to Healthy Sleep"

SLEEP STUDY (POLYSOMNOGRAM) REQUEST

PATIENT INFORMATION *** If you are sending a Face/Demographics sheet do not fill out this section***

Patient Name: _____ **DOB:** ___/___/_____

Address: _____

Phone: _____ **Cell:** _____ **SSN#:** _____-_____-_____

Medicare#: _____ **Medical#:** _____

Private Insurance: _____ **ID#:** _____

REASON FOR SLEEP STUDY

- ☐ Insomnia
- ☐ Snoring
- ☐ Obstructive Sleep Apnea (327.23
- ☐ Narcolepsy
- ☐ Hypertension
- ☐ Restless Leg Syndrome
- ☐ Sleep Walking
- ☐ Sleep Talking
- ☐ Periodic Limb Movement
- ☐ Disturbed Sleep
- ☐ Excessive Daytime Sleepiness
- ☐ Other _____

PATIENT CLINICAL INFORMATION

☐ Hypertension ☐ Arrhythmia ☐ CHF

☐ Patient Requires Oxygen flow @ _____LPM ☐ Intolerant of CPAP Therapy

Current Meds:

_____

Known Allergies: Other:_____

_____

STUDY ORDERED

- ☐ **PSG** - Diagnostic Baseline Sleep Study (**95810**)
- ☐ **Bipap Titration** (**95811**)
- ☐ **Split Night**/PSG + CPAP (**95811**)
- ☐ **Home Sleep Study** (**95806**)
- ☐ **CPAP Titration** Only (**95811**)
- ☐ **Consultation** (**99204**)

PHYSICIAN INFORMATION

Physician: _____

Address: _____

Phone: _____ **Fax:** _____ **Contact:** _____

Physician Signature: _____ **Date:** _____

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