PATIENT NAME:		
DOB:		PHONE:

Sleep Diagnostic Facility
Phone (605) 696-8062

MEDICAL JUSTIFICATION FOR POLYSOMNOGRAPHY (SLEEP STUDY) (Please check all that apply):

*****Please include a copy of the Face to Face visit documenting the required need for a Sleep Study*****

Sleep history: ____

*A combination of at least **TWO** of the following:*

- ☐ Excessive daytime sleepiness evidenced by an ESS >10, inappropriate daytime napping or sleepiness that interferes with daily activities not explained by other conditions.
- ☐ Witnessed apnea, snoring or gasping episodes associated with awakenings.
- ☐ Unexplained and documented hypertension or ischemic heart disease.
- ☐ Obesity defined as a BMI >30 Kg/m2
- ☐ Craniofacial or upper airway soft tissue abnormalities including adenotonsilar hypertrophy or neuromuscular disease.
- ☐ Moderate or severe CHF, stroke/transient ischemic attack, coronary artery disease or significant tachycardia or bradycardia arrhythmias in patients who have nocturnal symptoms suggestive of a sleep-related breathing disorder or otherwise are suspected of having sleep apnea.

Has patient had previous sleep study? YES NO If yes, when and where? ______________________________
If previous sleep study, please provide testing results.

Is patient oxygen dependent? YES NO Current PAP user? YES NO

Special indications: impaired cognition, insulin dependent, seizure disorder, physical impairment, wheelchair bound

Other ____

POLYSOMNOGRAPHY STUDY TYPE:

________ ***Home Sleep Test – 95806 –*** Exclusion criteria: CHF, Hx of V-Fib, SVT, moderate or severe lung disease, neuromuscular disorders, cognitive impairment, suspected sleep disorder other than OSA. Those patients should be tested in lab with technologist.

________ **Split-*night* – 95810 – 95811 –** *Minimum of 2 hours diagnostic followed by initiation and titration of CPAP/BiPAP therapy when indicated per protocol. Recommended for 1st study or reassessment of patients on therapy for several years.*

________ ***CPAP BIPAP ASV titration* – 95811 –** *therapy to be initiated at the start of the study and titrated per protocol. Recommended for 2nd/repeat study—Insurance may require split night depending upon date of previous study or patient's change in insurance carrier.*

PRN Sedative: Please indicate one of the following if you feel the patient would benefit from a sleep aid. Please dispense a sample to the patient or write a prescription for them to fill and bring with them the night of the study.

☐	Ambien (Zolpidem Tartrate)	5 mg _____	10 mg _____
☐	Sonata	5 mg _____	10 mg _____

Physician Signature ____ Date ____________________

Physician Name (Please Print) ____
Complete this form and FAX to (605) 696-8889.