PROVIDENCE HOSPITALS
Sleep Disorder Center

Downtown – Northeast

Providence
MIDLANDS PULMONARY • CRITICAL CARE
SLEEP MEDICINE

SLEEPMED
Science. Systems. Solutions.

Physician's Prescription & Certificate of Medical Necessity

For Diagnosis and Treatment of Sleep Disorders

PHN: 866-726-5031 FAX: 877-479-3625

Patient Information

Legal Name (Last, First, MI): _____ SSN: _____

Address: _____ DOB: _____ Male/Female _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status _____ Race: _____ Height: _____ Weight:_____

Emergency Contact: _____Relationship: _____Phone: _____

Please fax a copy of this completed form, a front and back copy of the patient's insurance card and patient's office notes.

Procedure Orders: Check ONE

☐	**Polysomnography (PSG)**	**First Night Study**	**CPT 95810**
☐	**CPAP Titration**	**Second Night Study**	**CPT 95811**
☐	**Bi-Level Titration**	**Second Night Study**	**CPT 95811**
☐	**Multiple Sleep Latency Test**	**Day Study**	**CPT 95805**
☐	**MSLT Urine Drug Screen**	**Dx: Excessive Daytime Sleepiness**	
☐	**Other:** _____		**CPT:** _____

Referral to Sleep Specialist after PSG for diagnosis and treatment:

- ☐ **Dr. C. Gregory Cauthen**
- ☐ **Dr. C. David Perry**
- ☐ **Dr. W. Shawn Ghent**

Special Needs:

Does patient have special needs? _____

_____

Preliminary Diagnosis:

☐ **G47.33 Apnea** ☐ _____ **Other:** _____

Clinical Symptoms: Check ALL that apply

- ☐ Witnessed Apnea – gasping episodes during Sleep
- ☐ Hypertension
- ☐ Excessive Daytime Sleepiness
- ☐ Falling Asleep While Driving
- ☐ Impaired Memory/Concentration
- ☐ Insomnia
- ☐ Loss of Muscle Control (Cataplexy)
- ☐ Loud Snoring
- ☐ Mood Disorder
- ☐ Morning Headaches
- ☐ Obesity
- ☐ Pulmonary Disease
- ☐ Restless Legs
- ☐ Other CV Disease: _____
- ☐ Other: _____

Ordering Physician Information:

Physician Name: _____ NPI #: _____

Address: _____ Specialty: _____

Phone/Cell: _____ Fax: _____ Email: _____

The above referenced patient has an absolute medical necessity for the item(s) listed above, based on the above preliminary diagnosis. I certify that the above prescribed item(s) is/are medically indicated and, in my opinion, reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition. I acknowledge that when I send a patient directly to the Providence Hospitals Sleep Center for a sleep study without a follow up visit with the interpreting physician, I will be responsible for reviewing the test results with the patient, and when appropriate will be ordering medical necessary treatment for this patient.

Ordering Physician's Signature: _____ **Time:** _____ **Date:** _____

APPOINTMENT DATE : _____ APPOINTMENT TIME : _____

LOCATION: _____