



Sleep Services of America, Inc.

Phone: 410.553-9167
or 800.755.7510
Fax: 410.553-6859
or 866.214.8799

SLEEP STUDY ORDERFORM ~ PRESCRIPTION

Note: So that your patient is studied in the safest and most efficacious manner, and to provide the most comprehensive interpretation of the study, SSA requires a copy of the patients H&P and Clinical Notes be forwarded (faxed) along with this study order

A D M I N	Patient: _____ S.S. #: _____ D.O.B.: _____
	Parent/Guardian: _____ Relationship: _____
	Home: _____ Work: _____ Other: _____
	Address: _____
	City/State: _____ Zip Code: _____ SEX: M or F
	Referring Dr: _____ Phone #: _____ Fax #: _____
	Referring Dr. Address: _____ UPIN #: _____
	Pediatrician: _____ Phone #: _____ Fax #: _____
	Prim. Ins. _____ Policy #: _____ Group #: _____
	Name Policy Holder: _____ S.S. #: _____ D.O.B.: _____
Sec. Ins. _____ Policy #: _____ Group #: _____	
Name Policy Holder: _____ S.S. #: _____ D.O.B.: _____	

DIAGNOSIS SUSPECTED

() Obstructive Sleep Apnea Other: _____

CLINICAL OBSERVATIONS / INDICATIONS

Tonsil Size: () None () Normal () Enlarged
 () Witnessed Apnea () Snoring () Irritability () Restless Sleep () Poor Attention
 () Obesity () Excessive Daytime Sleepiness () Other: _____

RELEVANT HISTORY/PHYSICAL Kindly fax copy of H&P or complete following information

Height: _____ in Weight: _____ lbs Bed Time: _____ Wake Time: _____ #Naps/Day: _____

OTHER MEDICAL DIAGNOSES OR PROBLEMS

M E D I C A L	1.) _____ 2.) _____ 3.) _____
	Medications: _____
	Special Accommodations Needed/Other Instructions (i.e. diet, language, disability, etc.): _____

Are there any factors which may influence this patient's ability to have a sleep study? () No () Yes, please Explain

SERVICES REQUESTED (please check one)

I N F O	() Full Service Sleep Order: Standard Sleep Study & Titration Study (if positive for OSA) 95810 & 95811
	() Standard Sleep Study: Baseline Polysomnogram "PSG" - R/O OSA 95810
	() Titration Sleep Study: () CPAP () BiLevel (check one) 95811 → <i>Please forward a copy of a recent</i>
	() Re-Titration Study, current Rx _____ cm H2O: () CPAP () BiLevel (check one) 95811 → <i>baseline sleep study if not performed at</i>
	() Polysomnogram followed by: (Please check one) 95810 & 95805 [] Multiple Sleep Latency Test (MSLT) for suspected Narcolepsy <u>OR</u> [] Maintenance of Wakefulness Test (MWT) for unexplained daytime sleepiness

Special Instructions: _____

I authorize SSA to perform services on the above patient according to the clinical protocols approved by the Medical Director.

PHYSICIAN SIGNATURE (required)

DATE

FOR OFFICE USE ONLY

Hospital Auth. To Schedule

Study Date: