PEDIATRIC SLEEP INSTITUTE

a department of

Date ______________ Patient Name ______________________________ DOB ______________

Parent/Guardian Name ______________________________ Primary Phone ______________

Address ______________________________ Alternate Phone ______________

Insurance: *Please fax copy of front & back of card*

Physician Orders and Special Instructions

- ❏ Evaluation by Sleep Specialist prior to Study
- ❏ Diagnostic Sleep Study (PSG)
- ❏ CPAP/BiPAP Titration Study (CPAP)
- ❏ Diagnostic Sleep Study (PSG), followed by Multiple Sleep Latency Test (MSLT)
- ❏ Split night study – PSG and CPAP
- ❏ EEG - Sleep deprived w/video > 1 hour
- ❏ EEG - 8 hours w/video
- ❏ EEG - 24 hours w/video
- ❏ Oxygen Titration

Known Diagnosis (ICD-9/10 codes) ______________________________

Physician(s) Name ______________________ Physician(s) Signature ______________________

Contact Name ______________________ Phone # ______________ Fax # ______________

Clinical Comments, Concerns or Special Instructions:

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Physician's Office Staff completing referral order MUST HAVE:

- H&P and/or most recent clinic notes

If your office has any pre-auth/pre-cert/predetermination for this sleep/EEG/CPAP study, if you could fax a copy and/or complete below:

Pre-cert/auth/determination#: ______________________ Date Range: ______________

CPT- 4 codes used for pre-cert/auth etc: ______________________________

6020 West Parker Road, Suite 325 Plano, Texas 75093 P (972) 403-2878 F (972) 419-8190

pediatricsleepinstitute.com