

**STRHS - Pulaski Respiratory Testing Order Form****1265 East College Street, Pulaski, TN 38478**

Scheduling Phone Number: (931) 538-1557

Scheduling Fax Number: (931) 363-9398



Patient Name: _____ DOB: _____

Social Security Number: _____ Male: _____ Female: _____ Ht: _____ Wt: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Preferred number to call? Home? Cell?

Insured Name: _____

Insurance Company: _____

Insured ID #: _____ Group #: _____

Insurance Phone #: _____ Authorization #: _____

CARDIAC: EKG (93005) ☐ **DIAGNOSIS** _____**PFT: DIAGNOSIS** _____

- | | | | |
|---|--|--|--|
| ☐ Simple PFT (94010) | ☐ Body Pleth-lung volumes (94726) | ☐ Arterial Blood Gas (36600) | ☐ DLCO-Lung Diffusion (94729) |
| ☐ MVV (94200) | ☐ Complete Pre & Post PFT (94060) | ☐ Nitrogen Washout-lung volumes (94727) | |

WIRELESS HOLTER HEART MONITOR: DIAGNOSIS _____

5 to 14 days (93246) ...please specify, • 5 days • 7 days • 14 days

SLEEP STUDY: ****CHECK IF PRECERTIFICATION IS NEEDED for Sleep Study** •

☐ PSG (95810)	☐ Split Night (95811)	☐ PSG/Split/CPAP Titration (95811) **Complete one night study PSG w/CPAP titration if indicated & automatic order for CPAP titration second night if criteria is not met in time for titration during the first night.
☐ Home Sleep Study (95806)	☐ Home Sleep w/CPAP Titration (95806/95811)	
☐ CPAP Titration (95811)	☐ MSLT (95805)	

Please check all that apply

- ☐ Excessive Daytime Sleepiness ☐ Witnessed Apnea ☐ Restless Sleep ☐ Morning Headaches ☐ Night Sweats ☐ Choking During Sleep
☐ Symptoms of Narcolepsy ☐ Nonrestorative Sleep ☐ Gasping During Sleep ☐ Hypertension ☐ Loud Snoring ☐ Frequent Arousals
 Other _____

Preferred DME Company & Fax #: _____**EPWORTH SLEEPINESS SCALE:***For Insurance Purposes: assessment below must be completed prior to ordering a Sleep Study***0 = Would NEVER Doze 1 = SLIGHT Chance of Dozing 2 = MODERATE Chance of Dozing 3 = HIGH Chance of Dozing**

Sitting and Reading: _____	Sitting inactive in a public place: _____
Passenger in a car under an hour: _____	Watching TV: _____
Lying down to rest in the afternoon: _____	In a car stopped in traffic: _____
Sitting & Talking w/someone: _____	Sitting quietly after lunch w/o alcohol: _____

CURRENT MEDICATIONS: For Sleep Study Order please list medication and dose, attach separate list if necessary.**PLEASE SEND H & P OR MOST RECENT OFFICE NOTE WITH ORDER FOR SLEEP STUDY****Letter of Medical Necessity**

The above listed symptoms are consistent with the presence of obstructive sleep apnea syndrome, a life threatening disorder. These findings warrant the medical necessity of overnight polysomnographic evaluation of this patient to assess the presence and severity of obstructive sleep apnea.

Referring Physician: _____ **NPI #:** _____**Physician Phone#:** _____ **Fax #:** _____**Physician Signature:** _____ **Date/Time:** _____