Sleep & CPAP Care Centers

Sleep better...Live better.

PHYSICIAN ORDER FORM:

THIS SERVES AS A PRESCRIPTION

(Please fax completed Order, Patient's Demographics & Insurance ID)

PATIENT NAME: _____ TEL.NO: _____

ADDRESS: _____DOB: _____

INSURANCE: _____ ID NO: _____

SERVICE REQUESTED

☐ **DIAGNOSTIC & CPAP TITRATION - CPT 95810 & 95811** *(Diagnostic all night/return for CPAP Treatment)*
☐ **DIAGNOSTIC STUDY - CPT 95810** (*Diagnostic all-night)*
☐ **SPLIT NIGHT STUDY - CPT 95811** *(Diagnostic & Treatment with CPAP)*
☐ **CPAP/BI-PAP/AUTO SV - CPT 95811** *(Titration to update pressure settings or previous OSA diagnosis)*
☐ **MSLT – CPT 95810 W/ 95805** *(Multiple Sleep Latency Test* used to *assess sleepiness)*
☐ **MWT CPT 95805** *(Maintenance Wakefulness Test used to assess wakefulnes)*
☐ **HST CPT 95806/G0399** (*Unattended Home Sleep Study with Apnea Link)*
☐ **POLYSOMNOGRAM WITH ORAL APPLIANCE - CPT 95810**

INDICATIONS FOR REFERRAL

☐ Snoring ☐ Fatigue ☐ Witnessed Apnea ☐ Daytime Sleepiness/Tiredness ☐ Morning Headaches ☐ Obesity
☐ RLS ☐ Insomnia ☐ CHF ☐ COPD ☐ Parasomnia ☐ Epilepsy ☐ Cataplexy ☐ Pulmonary Hypertension
☐ Stroke/Transient ischemic Attack ☐ Hypertension/Heart Disease ☐ Bradycardia Arrhythmias ☐ Bruxism
☐ Craniofacial Abnormalities ☐ Depression ☐ Hypnagogic Hallucination/Paralysis
☐ Other: _____

CPAP/BIPAP/AUTO/ORAL APPLIANCE & SUPPLIES

☐ **CPAP per sleep study pressure** ☐ **CPAP** at _____cmH2O ☐ **Bi-PAP** at ____/____cm/H2O
☐ **Auto-CPAP** (4-20cm H20) ____/____cm/H2O ☐ **Auto-SV** ☐ **Oral Appliance**
☐ MASK TYPE (*If known)* _____
☐ MASK & SUPPLIES PER PATIENT COMFORT *(Mask, Cushions, Tubing, Filters)*
Length of Need: _____(99 months = Lifetime) _____(years)

REFERRING PHYSICIAN

NAME: _____NPI: _____

TEL: _____FAX: _____

SIGNATURE: _____DATE: _____

TEL: (800)647-0314 **FAX: (800) 647-0315**

DUARTE	RANCHO CUCAMONGA	CORONA
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TEL:(626)357-9100	TEL:(9096)987-3535	TEL: (951)547-4579