R&M
Pacific Sleep Center

SLEEP STUDY PRESCRIPTION FORM

Tel: 562.343.7182 Fax: 562.343.7183
2990 E. Pacific Coast Hwy, Suite A, Long Beach, CA 90804

Please print clearly: **Patient's Information**

Last Name: _____ First name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell/Work Phone: _____

Date of Birth: _____ / _____ / _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____

Patient's Clinical Information

Does the patient Have: ☐ Hypertension ☐ CHF

☐ Cardiac Arrhythmia ☐ Other: _____

Does the patient require oxygen? ☐ No ☐ Yes _____LPM

What are the patient's known allergies?

What are the patients current medications?

Reasons for ordering Study (Clinical impressions)

- ☐ Excessive Daytime Sleepiness
- ☐ Obstructive Sleep Apnea
- ☐ Restless Legs Syndrome
- ☐ Periodic Limb Movements
- ☐ Strange Behaviors During Sleep
- ☐ Other or Undetermined:
- ☐ Snoring
- ☐ Insomia
- ☐ Narcolepsy
- ☐ Sleepwalking
- ☐ Sleeptalking

Referring Physician

Physician: _____

Tel: ( ) _____

Address: _____

City: _____ State: _____ Zip: _____

Fax: ( ) _____

Office Contact: _____ Date of this order: _____

Consult or Sleep Study Ordering

☐ Diagnostic Polysomnography (PSG)	95810
☐ CPAP Titration / Trial with CPAP	95811
☐ Split Night Polysomnography	95811
☐ Multiple Sleep Latency Test (MSLT)	95805
☐ MSLT / Multiple Wakefulness Test	95810
☐ (MWT) daytime test R/O narcolepsy (Conducted morning after PSG	
☐ Other: _____	

Physcian's Signature: _____ Date: _____

Lic#: _____ NPI#: _____ UPIN#: _____

****COPIES of all Insurance Cards & Relevant Cliniacal Notes must be faxed with order to expedite processing****