



SLEEP MANAGEMENT SERVICES
501.224.5200 FAX: 501.224.5208
EVALUATION AND MANAGEMENT ORDER FORM

ATTACH: PATIENT DEMOGRAPHIC & INSURANCE INFORMATION, CURRENT H&P AND LAST TWO OFFICE VISIT NOTES

Patient Name: _____ **SSN:** _____ - _____ - _____ **Date:** ____/____/____

DOB: ____/____/____ **HT:** _____ **WT:** _____ **PHONE:** (____) _____ - _____

HISTORY OF PRESENT ILLNESS / SUPPORTING DX AND SYMPTOMS:

<input type="checkbox"/> Loud or Disruptive Snoring (R06.83)	<input type="checkbox"/> Witnessed Apnea (G47.30)	<input type="checkbox"/> Morning Headaches (R51)
<input type="checkbox"/> Excessive Daytime Sleepiness (G47.10)	<input type="checkbox"/> Fatigue or Malaise (R53.83)	<input type="checkbox"/> Inappropriate daytime naps (G47.41)
<input type="checkbox"/> Sleep Fragmentation (F51.8)	<input type="checkbox"/> Sleep Walking/Talking (G47.50)	<input type="checkbox"/> Muscle Weakness (M62.81)
<input type="checkbox"/> Choking/gasping during sleep (R06.89)	<input type="checkbox"/> Nocturia (R35.1)	<input type="checkbox"/> Impaired Cognition (G31.84)
<input type="checkbox"/> Shortness of Breath/Dyspnea (R06.00)	<input type="checkbox"/> Nocturnal Leg Movements	<input type="checkbox"/> Mood Disorder (F39)
<input type="checkbox"/> Hypoxemia (G47.36)	<input type="checkbox"/> PAP compliance problems (Z91.19)	<input type="checkbox"/> Other: _____

PAST MEDICAL HISTORY:

<input type="checkbox"/> Hypertension (I10)	<input type="checkbox"/> Diabetes (E11.9)	<input type="checkbox"/> Obesity (E66.9)	<input type="checkbox"/> CHF (I50.9)	<input type="checkbox"/> Ischemic Heart Disease (I25.9)
<input type="checkbox"/> COPD (J44.9)	<input type="checkbox"/> Seizures (G40.919)	<input type="checkbox"/> Stroke (I63.50)	<input type="checkbox"/> Atrial Fib (I48.91)	<input type="checkbox"/> Other: _____
Previous Sleep Study: <input type="checkbox"/> YES <input type="checkbox"/> NO When: _____ Where: _____				
Currently on CPAP: <input type="checkbox"/> YES <input type="checkbox"/> NO How long: _____ Pressure: _____				

IMPRESSION / PRIMARY DX: MUST HAVE AT LEAST ONE PRIMARY DX

<input type="checkbox"/> G47.30 Sleep Apnea, unspecified	<input type="checkbox"/> G47.61 Periodic limb movements during sleep
<input type="checkbox"/> G47.33 OSA-witnessed apnea during sleep	<input type="checkbox"/> G25.81 Restless legs while falling asleep
<input type="checkbox"/> G47.10 Excessive Daytime Sleepiness / Hypersomnia	<input type="checkbox"/> G47.20 Circadian Rhythm Sleep Disorder
<input type="checkbox"/> F51.01 Primary Insomnia (include another dx for sleep testing)	<input type="checkbox"/> G47.419 Narcolepsy <input type="checkbox"/> G47.411 with cataplexy
<input type="checkbox"/> G47.36 Hypoxemia	<input type="checkbox"/> Other: _____

TREATMENT PLAN: I authorize the following tests and evaluations as medically necessary based on the above symptoms and diagnosis.

<input type="checkbox"/> Evaluate and Treat	CPT 95810, 95811, 95805 and 95806	Polysomnogram, with 2 nd night CPAP Titration, and/or MSLT, and/or Home Sleep Test, if indicated or required by insurance
<input type="checkbox"/> Polysomnogram (PSG)	CPT 95810	1 st Night Diagnostic Study for Evaluation only
<input type="checkbox"/> PAP Titration	CPT 95811	2 nd Night Titration following Diagnostic Study with DX of OSA
<input type="checkbox"/> Follow up Titration Study <input type="checkbox"/> CPAP <input type="checkbox"/> BiLevel <input type="checkbox"/> ASV	CPT 95811	For Patients currently using PAP therapy (patient must meet requirements to qualify for BiLevel or ASV)
<input type="checkbox"/> Split Night Study	CPT 95811	Initial Diagnostic period followed by CPAP initiation for AHI>40
<input type="checkbox"/> MSLT	CPT 95805	Daytime Nap Study for EDS (PSG performed the preceding night)
<input type="checkbox"/> Home Sleep Testing	CPT 95806, G0399 (codes vary by insurance)	Sleep Study - unattended, Home Sleep Study - unattended, Type III device
<input type="checkbox"/> Consultation	<input type="checkbox"/> Pre-Study <input type="checkbox"/> Post Study	Evaluation and Management of Patient for Sleep Complaints

Special Instructions:

Provider Name: _____ **NPI:** _____

Phone: (____) _____ - _____ **Fax:** (____) _____ - _____

Provider Signature: _____ **Date:** ____/____/____