UNITED DIAGNOSTICS
SLEEP STUDIES • VEEG • DME

SLEEP STUDY EXPRESS ORDER FORM

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Patient Name _____ ❑ *Male* ❑ *Female* *DOB* _____ / _____ / _____

Patient Address _____ *SS #* _____

City _____ *State* _____ *Zip* _____ *Height* _____ *Weight* _____

Patient Tel: H (____ *)* _____ *W (* ____ *)* _____ *C (* ____ *)* _____

*E-mail*_____

Insurance _____ *ID #* _____

Is the patient the insured ❑*Yes* ❑*No* *If no, insured's name & DOB* _____

TYPE OF STUDY REQUESTED

❑ *DIAGNOSIS & TREATMENT – Sleep Study, Titration and initiation of therapy if needed**
❑ *PSG, Initial nocturnal polysomnography**
❑ *TITRATION, Follow-up study with PAP titration*
❑ *MSLT, Multiple sleep latency test (nap studies)*
❑ *PSG, followed by MWT*
❑ *SPLIT, baseline study followed by PAP titration*
❑ *MWT, Maintenance of wakefulness test*
❑ *PSG, followed by MSLT*
❑ *Adaptive Servo-Ventilation (ASV) titration*

***Proceed with HST (95806) and Sleep Profiler (95827) if insurance criteria not met**

PATIENT HISTORY

Patient's chief complaint (mandatory) _____

Significant Co-Morbidities *Please check all that apply:*

Suspected Complex Sleep Disorders	❑ *Narcolepsy*	❑ *Circadian rhythm*	❑ *Parasomnia's*	❑ *Restless Legs*
Cardiac Disease	❑ *Heart Failure*	❑ *Arrhythmia*	❑ *Pulmonary hypertension*	❑ *MI*
Lung Disease	❑ *COPD*	❑ *Asthma*	❑ *Chronic Respiratory failure*	
Neurological Disease	❑ *PD/ALS*	❑ *Cognitive Impairment*	❑ *Neuromuscular Weak*	

Sleep Health Maintenance History *Please check all that apply:*

❑ *Loud snoring*	❑ *Twitching or kicking of legs while sleeping*	❑ *Stroke*
❑ *Hypertension*	❑ *Obesity*	❑ *Nocturnal seizures*
❑ *Excessive daytime sleepiness*	❑ *Gasping for air at night*	❑ *Type 2 Diabetes*

Has the patient been tested previously? ❑ *Yes* ❑ *No*
(If yes, please fax copy of results) *Date of Last Study* _____

Referring Physician _____ *Tel: (* _____ *)* _____

Address _____ *Fax: (* _____ *)* _____

Signature _____ *NPI #* _____ *Date:* _____