Ascension Seton

CHECK DESIRED LOCATION
Ascension Seton Hays____
Ascension Seton Williamson____
First Availability____

Date:_____ Patient Name:_____ DOB: _____

Mobile Number: _____ Home:_____ Work:_____

Insurance Provider:_____ Policy Number:_____ Group Number:_____

Primary Care Provider Name:_____ Primary Care Provider Phone Number:_____

FOR USE BY CENTRAL SCHEDULING

Authorization for Study: _____ Authorization Date Range: _____

Stop Bang Score:_____ (0-2 low risk, 3-4 Intermediate risk, >5 high risk)

SYMPTOMS

☐ Disrupted Sleep (G47.00) ☐ Snoring (R06.83) ☐ Dry Mouth (R06.5) ☐ Morning Headaches (G44.1)

☐ SOB upon awakening (R06.02) ☐ Hypertension (I10) ☐ Other _____

PATIENT MEDICAL HISTORY

☐ Hypertension (CM I10)
☐ COPD (CM J44.9)
☐ Stroke (CM I63.50)
☐ Heart Disease (CM I51.9)
☐ CHF (CM I50.9)
☐ Type I Diabetes (CM E10.9)
☐ Type II Diabetes (CM E11.9)
☐ Headaches (CM R51)
☐ Depression (F33)
☐ Other_____

TYPE OF STUDY BEING ORDERED

New patient: High risk+ Comorbid conditions

☐ Attended Split night – If AASM criteria are met, I authorize the CPAP Titration the same night. (**If pre-authorization is required, will need authorization for both PSG 95810 and Titration 95811**)

New patient: Moderate to High risk- no comorbid conditions

☐ Home Sleep Apnea Test (95800) **Does machine need to be mailed to patient Yes or No**

☐ Comprehensive Care Plan (Sleep consultation, overnight sleep study with follow-up CPAP/Bi-Level if indicated, home CPAP/Bilevel coordination and support, and follow up).

New patient: Negative Home sleep test but still suspect OSA

☐ PSG (95810) – Diagnostic required prior to titration study

Follow up patient: Positive diagnostic sleep study (PSG, Split night or Home sleep test)

☐ Titration Study (95811)

New patient: Evaluate daytime sleepiness (e.g. Narcolepsy, Truck driver)

☐ MSLT or MWT (95805)

Provider Signature: _____ Date:_____

NPI: _____

Ascension Seton

Sleep Study Referral Form

Name: **DOB:** **Physician:**

Age: **Date:** **Physician Office #:**

Pt. Phone #: **Physician Fax #:**

Physician Address:

STOP-BANG Sleep Apnea Questionnaire

STOP		
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel TIRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone OBSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood PRESSURE?	Yes	No

BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

SCORE		

High risk of OSA: (Yes-5-8) **Intermediate risk of OSA: (Yes 3-4)** **Low risk of OSA: (Yes 0-2)**

FAX PRE-OPERATIVE ASSESSMENT FORM, SLEEP STUDY REFERRAL FORM, H&P AND FACE SHEET TO FAX NUMBER: 512-324-3415