



# Dream Sleep Centre Inc

## SLEEP MEDICINE SERVICE REQUEST

1349 Camino Del Mar, Suite F Del Mar, CA 92014  
 Phone: (858) 755-1166 Fax: (888) 399-9098

PATIENT NAME: \_\_\_\_\_ M  F  DOB: \_\_\_\_\_  
 CONTACT PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
 INSURANCE: \_\_\_\_\_ SUBSCRIBER ID # \_\_\_\_\_

### Indication/Suspected Diagnosis

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> OSA (G47.33)      | <input type="checkbox"/> Daytime Somnolence (R40.0)        | <input type="checkbox"/> Obesity (E66.9)              |
| <input type="checkbox"/> CSA (G47.31)      | <input type="checkbox"/> Narcolepsy (G47.419)              | <input type="checkbox"/> Essential Hypertension (I10) |
| <input type="checkbox"/> Snoring (R06.83)  | <input type="checkbox"/> Restless Legs Syndrome (G25.81)   | <input type="checkbox"/> Diabetes (J44.9)             |
| <input type="checkbox"/> Insomnia (G47.00) | <input type="checkbox"/> Periodic Limb Movement (G47.61)   | <input type="checkbox"/> COPD (J44.9)                 |
| <input type="checkbox"/> Fatigue (R53.83)  | <input type="checkbox"/> Cheyne-Stokes Respiration (R06.3) | <input type="checkbox"/> CAD (I25.10) / CHF (I50.9)   |
| <input type="checkbox"/> Bruxism (G47.63)  | <input type="checkbox"/> Parasomnia (G47.50)               | <input type="checkbox"/> Other:                       |

### Requested Service

- |   |   |
|---|---|
| <input type="checkbox"/> Full Consultation & Management by sleep specialist at Dream Sleep Centre Inc.<br><i>Sleep Specialist will perform a consultation to review sleep complaints, order a specific type of sleep study, and then will perform follow up evaluation with patient and manage appropriate treatment.</i> | <input type="checkbox"/> Split Night Sleep Study (CPT-958-11)<br><i>Must meet AASM criteria AHI&gt;10 in first 2 hours of testing</i> |
| <input type="checkbox"/> Diagnostic Sleep Study (CPT-95810)<br><i>Attend overnight polysomnogram</i>  | <input type="checkbox"/> Home Sleep Study (cpt-95806)   |
| <input type="checkbox"/> PAP Titration Study (CPT-95811)<br>CPAP <input type="checkbox"/> BiPAP <input type="checkbox"/> ASV <input type="checkbox"/> Oxygen <input type="checkbox"/>   | <input type="checkbox"/> Oral Appliance HST Efficacy Study (CPT-95806)  |
| <input type="checkbox"/> Multiple Sleep Latency Test (CPT-95805)<br><i>Daytime test to diagnose or rule out Narcolepsy</i>  | <input type="checkbox"/> Maintenance of Wakefulness Test (CPT-95805)  |
|   | <input type="checkbox"/> PAP-NAP Study (CPT-95807)  |

REFERRING PHYSICIAN: \_\_\_\_\_

PHYSICIAN PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

NPI#: \_\_\_\_\_

REFERRING PHYSICIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_