+rmc
the Regional Medical Center

SleepMed

Physician's Prescription & Certificate of Medical Necessity

For Diagnosis and Treatment of Sleep Disorders

• PHN: 866-726-5031 • FAX: 877-479-3625

Patient Information

Legal Name (Last, First, MI): ______________________________ SSN: ______________

Address: ______________________________ DOB: __________ Male/Female ________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Marital Status ______________ Race: ______________ Ethnicity: ______________

Emergency Contact: ______________ Relationship: ______________ Phone: ______________

Please fax a copy of this completed form, a front and back copy of the patient's insurance card and OFFICE NOTES.

Procedure Orders: Check ONE

	Procedure	CPT
☐	Baseline Polysomnography (PSG)	CPT 95810
☐	CPAP Titration ONLY	CPT 95811
☐	Bi-Level Titration ONLY	CPT 95811
☐	Multiple Sleep Latency Test (Day Study)	CPT 95805
☐	Split Night Study w/PAP titration per protocol	CPT 95811

Referral to Sleep Specialist after PSG:

☐ **Refer patient to Dr. George Augustine, medical director, for diagnosis and treatment of sleep disorders**

SPECIAL NEEDS:

- ☐ **Oxygen** ☐ **Nasal Cannula** ☐ **Mask** **______LPM**
- ☐ **Transport by Stretcher**
- ☐ **Wheel Chair**
- ☐ **Handicapped/Disabled**
- ☐ **>400 LBS**

Other::______________________________

Preliminary Diagnosis:

☐ G47.33 Apnea ☐ Other: ______________

Clinical Symptoms: Check ALL that apply

- ☐ Witnessed Apnea – gasping episodes during Sleep
- ☐ Hypertension
- ☐ Atrial Fibrillation
- ☐ Excessive Daytime Sleepiness
- ☐ Falling Asleep While Driving
- ☐ Impaired Memory/Concentration
- ☐ Type 2 Diabetes
- ☐ Loud Snoring
- ☐ Mood Disorder
- ☐ Morning Headaches
- ☐ Obesity
- ☐ Pulmonary Disease
- ☐ Restless Leg Syndrome
- ☐ Other: ______________

Ordering Physician Information:

Physician Name: ______________________________ NPI #: ______________

Address: ______________________________ Specialty: ______________

Phone/Cell: ______________ Fax: ______________ Email: ______________

The above referenced patient has an absolute medical necessity for the item(s) listed above, based on the above preliminary diagnosis. I certify that the above prescribed item(s) is/are medically indicated and, in my opinion, reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition. I acknowledge that when I send a patient directly to Regional Medical Center Sleep Center for a sleep study, without a follow up visit with the interpreting physician, I will be responsible for reviewing the test results with the patient, and when appropriate will be ordering medical necessary treatment for this patient.

Ordering Physician's Signature: ______________________________ **Date:** ______________

APPOINTMENT DATE: ______________________________ APPOINTMENT TIME: ______________