ACADEMY DIAGNOSTICS LLC
ADULT & PEDIATRIC SLEEP CENTER

SLEEP & NEURODIAGNOSTIC DISORDERS SERVICES ORDER FORM

12727 Kimberley Lane, Houston, TX 77024 | **P:** 832.659.0248 | **F:** 832.667.8611

AMERICAN ACADEMY OF SLEEP MEDICINE — ACCREDITED FACILITY MEMBER

JOSHUA S. ROTENBERG, MD
Board Certified in Neurology (CN),
Pediatrics, Sleep Medicine & Epilepsy

SARAT SUSARLA, MD
Board Certified in Pediatrics,
Pulmonology & Sleep Medicine

MICHELLE NWOSU, MD
Pediatrics,
Neurology & Neuropysiology

PATIENT INFORMATION

NAME: ______ FOLLOW-UP APPOINTMENT / SURGERY DATE

GENDER: M ☐ F ☐

PHONE: (HOME) ______ (CELL) ______ (WORK) ______

DOB: ______ SS#: ______ EMAIL: ______

PROCEDURES & SCREENING

PEDIATRIC SLEEP PROCEDURES

- ☐ **95782 Pediatric Diagnostic Polysomnogram** (Sleep Study)
- ☐ **95783 Pediatric CPAP Titration** (If Polysomnogram is positive for OSA or a previous study was performed and results are available)
- ☐ **Other** ______

ADULT SLEEP PROCEDURES

- ☐ **95810 Diagnostic Polysomnogram** (Sleep Study) (HST if required by insurance)
- ☐ **95811 CPAP Titration** (If polysomnogram is positive for OSA or a previous study was performed and results are available.)
- ☐ **95811 Split Night Study** (Treatment portion to be performed only if the patient meets criteria.)

- ☐ **95805 Multiple Sleep Latency Test (MSLT)** following a Diagnostic Polysomnogram
- ☐ **95805 Maintenance of Wakefulness Test (MWT)**

DIAGNOSIS

Must indicate at least one qualifying diagnosis:

- ☐ **G47.33** Obstructive Sleep Apnea
- ☐ **G47.30** Sleep Apnea, unspecified
- ☐ **E66.01** Obesity Hypoventilation Syndrome
- ☐ **G47.61** Periodic Limb Movement Disorder
- ☐ **F51.8** Sleep Related Movement Disorders, unspecified
- ☐ **G47.419** Narcolepsy
- ☐ **F51.13** Organic Hypersomnia/EDS
- ☐ **G47.54** Parasomnias
- ☐ **E66.01** Morbid Obesity (Needs additional diagnosis)
- ☐ **G47.20** Disruption of 24 hr Sleep/Wake Cycle
- ☐ **Other Qualifying Code** ______

PRE-EXISTING CONDITIONS

NOTE: Please indicate if the following are applicable

- ☐ **Pulmonary Disease** (Respiratory Failure, COPD, Hypoxemia)
- ☐ **Neuromuscular Disease** (ALS, Parkinson's, etc.)
- ☐ **Significant Cardiac Disease** (CHF, Atrial Fibrillation, Pulmonary Hypertension, Arrhythmias)
- ☐ Other ______

PRE-SCREENING

- ☐ Ht: ______ Wt: ______
- ☐ Neck Circumference ______ ☐ BMI ______
- ☐ *Epworth Sleepiness Scale (ESS = 10 or more)

Referring Provider Preferences

- ☐ **Provide pre-test consultation for appropriate testing services with follow up evaluation and initiation of therapy as indicated with consultation notes to referring provider.**
- ☐ **Provide sleep apnea management if clinically indicated by testing results with consultation notes forwarded to referring provider.**

NEURODIAGNOSTIC SERVICES

______ **Routine EEG** (Greater than 61 minutes)

Diagnosis: ______ **R40.4** Transient alteration of awareness
______ **R55** Syncope and collapse
Other Diagnosis: ______

______ **Extended Video EEG** (Greater than 14 hours)

Diagnosis: ______ **G40.389** Epilepsy, unspecified
______ **R56.9** Other Convulsions (e.g. seizure NOS)
______ **R56** Convulsions

COMMENTS/SPECIAL INSTRUCTIONS: ______

PHYSICIAN INFORMATION

ORDERING PHYSICIAN: ______ SIGNATURE ______

PHONE: ______ FAX ______ NPI ______

By signing you are ensuring that the physician has seen the patient face-to-face and has documented the patient's sleep complaint. Please provide clinical documentation, demographics, insurance information and previous sleep studies if applicable.