NYMetroSleep & Neurology Center

Center for the diagnosis and treatment of sleep disorders

Phone: (718) 684-6393 Fax: (718) 684-6395 or (718) 684-6396

AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE SLEEP — ACCREDITED MEMBER CENTER

Request for Polysomnography (Sleep Study)

PATIENT INFORMATION:

Last Name:_____First:_____MI:_____Sex: M F

Address:_____City:_____State:_____Zip:_____Email:_____

Phone (H):_____(W)_____(C)_____Date of Birth:_____

Primary Insurance Carrier:_____Policy/ID#_____

Secondary Insurance:_____Policy/ID#_____

Please submit a photocopy of the patient's insurance card (FRONT AND BACK)

TEST REQUESTED: (Check Applicable)

- ☐ **Please schedule a consultation with a Sleep Specialist**
- ☐ **Full service polysomnography (PSG), if positive CPAP/BiPAP/ASV Titration**
- ☐ Dental Sleep Medicine Evaluation/Oral Appliance Therapy
- ☐ Split-night polysomnography (at least 2 hrs of diagnostic study followed by CPAP/BiPAP Tiration if needed)
- ☐ Multiple Sleep Latency Test (MSLT) or Maintenance of Wakefulness test (MWT)
- ☐ Home Study
- ☐ Consultation with Behavioral Sleep Medicine Specialist (For Insomnia)
- ☐ CPAP Center- EVALUATION (CPAP Machine order/supplies/mask fitting/maintenance)

Indications: (Check Applicable)

- ☐ Obstructive Sleep Apnea
- ☐ Parasomnia
- ☐ Physiological insomnia (307.42)
- ☐ Circadian Rhythm Disorder
- ☐ Central Sleep Apnea (327.21)
- ☐ RLS/PLMD (333.94/327.51)
- ☐ Pre/Post Surgery
- ☐ Narcolepsy (347.00)
- ☐ Other:_____
- ☐ Neuroproblem/Autism

Symptoms:

- ☐ Daytime Sleepiness
- ☐ Witnesses Apneas
- ☐ Arrhythmia
- ☐ GERD
- ☐ Diabetes
- ☐ Shortness of Breath
- ☐ Choking During Sleep
- ☐ HTN
- ☐ Dyslipidemia
- ☐ Non-restorative sleep
- ☐ Obesity

MEDICAL HISTORY: (Faxed history and physical preferred)

- ☐ Asthma
- ☐ Emphysema
- ☐ Seizures
- ☐ Ischemic heart disease
- ☐ Diabetes
- ☐ Stroke
- ☐ Large tonsils
- ☐ Nasal obstruction
- ☐ Enlarged tongue
- ☐ Psychiatric Disorder
- ☐ Hypertension
- ☐ Claustrophobia
- ☐ Other_____

NEUROLOGY

- ☐ Consultation
- ☐ EMG / NCV
- ☐ EEG
- ☐ VNG
- ☐ VEEG

☐ 72 HOURS ☐ 48 HOURS ☐ 24 HOURS

Reason for Referral/Please include Medical Notes:_____

_____

REFERRING PHYSICIAN

NAME:_____SIG._____DATE:_____

ADDRESS:_____PHONE:_____

_____FAX:_____

NPI:_____EMAIL:_____

PATIENT'S PCP:_____PHONE:_____