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Please Provide: ☐ Demographics ☐ Insurance Card ☐ Medical History/Physical

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Gender:_____

Address: _____ City/State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____Email:_____

Primary Ins. Co.: _____Subscriber #: _____ Group #: _____ Primary Ins. Phone: _____

SLEEP STUDY OPTIONS:	**DIAGNOSIS:** Check ALL that apply to patient's diagnosis-condition:
☐ Baseline Diagnostic Study (95810) ☐ Split Night Study(95811) ☐ Home Study if split not authorized ☐ CPAP/BIPAP Titration (95811) ☐ BIPAP (ST/ASV) (95811) ☐ Home Sleep Test (HST 95800/95806) ☐ MSLT (95805)	☐ Obstructive Sleep Apnea (G47.30- G47.33 peds) ☐ Parasomnia (RLS-PLM) (G47.50) ☐ Excessive Daytime Sleepiness (Hypersomnia) (G47.10) ☐ Snoring Habitual (R06.83) ☐ Primary Central Sleep apnea (G47.31) ☐ Other: _____

Have you ever been told that you stop breathing while you asleep?	**Yes or No**	**8**
Do you feel excessively sleepy during the day?	**Yes or No**	**4**
Do you snore or have been told that you snore?	**Yes or No**	**4**
Have you taken medications for or been diagnosed with high blood pressure?	**Yes or No**	**2**
Do you kick or jerk your legs while sleeping?	**Yes or No**	**3**
Do you have trouble staying asleep or going to sleep?	**Yes or No**	**4**

Physician Name: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact: _____ Email: _____

I have ordered this test based on a comprehensive sleep evaluation for this patient and have determined that this patient has a high pretest probability of obstructive sleep apnea (OSA).

PHYSICIAN/DDS SIGNATURE: _____ **DATE:** _____

Please Fax Order to (562) 291-2858 or email to cassandra@everestsleepcenter.com