PATIENT ADULT ORDER FORM
OUMC SLEEP DISORDERS CENTER 2015

A. Patient Information		
Patient Name: ____________________________	Patient DOB:__________________	Age (years): ______________
Daytime Phone:___________________________	Evening Phone: ____	

B. Medical/Sleep History/Symptoms/Diagnosis (check all that are appropriate)					
	Excessive Sleepiness		Apnea		REM Behavior Disorder
	Hypertension		Leg cramps, movements/jerks		Arrhythmia (specify): ______
	Tonsils enlarged		Diabetes		Other (specify):_______

	C. Study Requested (please check one)	**Conditions**
	Split Night: Diagnostic sleep study with CPAP titration (95811 or 95810)	95811 will be performed ONLY if AASM criteria are met/otherwise 95810 will be done
	Titration: All night CPAP/Bilevel titration (95811)	Previous study date: ___________ Must have documented diagnosis of Obstructive Sleep Apnea
	MSLT/MWT (95805)	Normal PSG the previous night
	Home sleep test (G0399)	
	Other (Please specify) ___________________________	

D. The following documents **must** be provided by the referring physician for **all** patients:

- ☐ H&P (must be within the last 6 months) to include special needs (wheelchair, oxygen, feeding tubes)
- ☐ Demographics sheet
- ☐ Recent copy of insurance information

E. If the patient has obstructive sleep apnea, would the referring physician prefer (check ONE):

- ☐ The referring physician facilitates follow up care of the patient, including DME equipment
- ☐ The interpreting sleep physician facilitates DME equipment, but not follow up care
- ☐ The patient is referred to the Sleep Clinic at OU Physicians for follow up care, including DME

F. Referring Physician Information

Requesting Physician Name: ____ NPI #: __________________________

Attending Physician Name (if different): ________________________________ NPI #: __________________________

PCP Name: ____ Phone: _______________ Fax:__________________

Clinic Contact Name*: ___________________________________ Phone: _______________ Fax: __________________

(*contact at referring clinic for questions and fax number for all sleep study information)

Requesting Physician Signature: ____ Date/Time: _____________

Please fax all information to 405-271-6690
Please refer questions to 405-271-5605

OFFICE USE ONLY

Date Fax Received ______________ **Date of Appointment** ____________
Date Physician Notified ______________ **Date Patient Notified** ____________
Approved ______ **Denied** ______ **Signature of Medical Director** _____________________________________