



Falcon Sleep Center
 120 Alexandria Blvd.
 Suite 19
 Oviedo, FL 32765

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 Fax: 407-365-3034
 Toll Free: 1-855-5FALCON
 (1-855-532-5266)
www.falconsleepcenter.org

Falcon Sleep Center Metrowest
 6000 Metrowest Blvd.
 Suite 104
 Orlando, FL 32835

Polysomnography Medical Request Form
Fax back to: 407-365-3034

EIN: 11-3812755
NPI: 1700078979

Falcon Sleep Center OVIEDO (AASM) Falcon Sleep Center METROWEST Patient Choice

Patient Name: _____ DOB: _____

Insurance: _____ Member ID: _____

Address: _____

Home Phone: _____ Work/ Mobile Phone: _____

Any significant medical history? Yes No

If Yes, please specify: _____

Suspected Diagnosis (Check appropriate boxes):

- | | |
|--|---|
| <input type="checkbox"/> Obstructive Sleep Apnea (OSA) | <input type="checkbox"/> REM Behavior Disorder |
| <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Restless Legs/Periodic Limb Movement Disorder | <input type="checkbox"/> Hypersomnia ICD-9 Code: _____ |
| <input type="checkbox"/> Morbid Obesity | <input type="checkbox"/> Other (specify) _____ |

Sleep History/Symptoms (Check appropriate boxes):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Snoring | <input type="checkbox"/> Muscle/joint aches | <input type="checkbox"/> Wakes up choking |
| <input type="checkbox"/> Witnessed apneas | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent nightmares |
| <input type="checkbox"/> Difficulty initiating sleep | <input type="checkbox"/> Impotence | <input type="checkbox"/> Cataplexy | <input type="checkbox"/> s/p surgery for OSA |
| <input type="checkbox"/> Morning headaches | <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Sleep paralysis | <input type="checkbox"/> Dizziness/Vertigo |
| <input type="checkbox"/> Nocturnal teeth grinding | <input type="checkbox"/> Acting out dreams | <input type="checkbox"/> Leg movements | |

Relevant Medical History (Check appropriate boxes):

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> CHF | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> Pulmonary hypertension | <input type="checkbox"/> CAD | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Anxiety disorder |
| <input type="checkbox"/> Pulmonary disease | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Claustrophobic | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Arrhythmia (VT/Afib) | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Latex allergies | <input type="checkbox"/> Other |

Previous Sleep Study? **Y** **N** If yes, where? _____ when? _____

Procedures Requested (Check appropriate boxes):

- Include Pulmonologist Consultation
- Overnight Polysomnography (CPT: 95810)
- Positive Airway Pressure (CPAP) Titration (CPT: 95811)
- Combined Overnight Polysomnography and CPAP Titration (Split Night Study) (CPT: 95811)
- Narcolepsy Screen (Overnight Polysomnography followed by MSLT) (CPT: 95810 & 95805)
- Multiple Sleep Latency Test (MSLT) (CPT: 95805)

Supplemental oxygen will be administered when indicated and as referring physician, you will be notified.

- Authorization for Ambien or other sleep aid at bedtime.** (Patient Brings Medication)

Physician Name: _____ **NPI #:** _____ **EIN #:** _____

Signature: _____

Specialty: Pulmonary Neurology ENT Cardiology Internal Medicine Family Practice **Other (please specify):** _____

Address: _____ **Email:** _____

City: _____ **State:** _____ **Zip:** _____ **Contact Person:** _____

Phone: _____ **Fax:** _____

PLEASE ATTACH/FAX PATIENT DEMOGRAPHICS
(Include Insurance Card and brief H&P relating to their possible sleep disorder)