WNJ Wilson N. Jones
REGIONAL MEDICAL CENTER

Sleep Center Ordering Form
Call (903) 870-3604
Fax (903) 891-2715

Patient Name:_____ **DOB:**_____
Last First MI

Primary Phone:_____ **Secondary Phone:**_____

Insurance:_____ **Secondary Insurance:**_____

Ordering Physician:_____ **Phone:**_____ **Fax:**_____

PreCert #_____

Mark with √

PRIMARY DX			SECONDARY DX		
G47.33		OSA	R06.83		Loud or Disruptive snoring
G47.10		Excessive Daytime Sleepiness/Hypersomnia	R40.0		Somnolence or Drowsiness
G47.41		Narcolepsy – Daytime sleep attacks	R53.83		Fatigue or Malaise
G47.30		Insomnia with apnea	E66.9		Obesity
G47.61		Periodic limb movement	E66.01		Morbid Obesity
G25.81		Restless legs while falling asleep	F51.8		Shift Work Disorder
		Other:			Other:

Orders: **Study Date:**_____ **Time:**_____

Mark with √

	PSG (Diagnostic only. Pt may be split if an AHI>40 is indicated)
	Split-Night (1st night PSG w/possible titration, if pt has an AHI>15)
	CPAP/BiPAP Titration Study (2nd night only)
	CPAP/BiPAP Re-Titration Study (Evaluation of PAP pressures)
	PSG w/Multiple Sleep Latency Test (Daytime nap study for EDS w/PSG performed the preceding night)
	Maintenance of Wakefulness Test (Daytime nap study for daytime wakefulness w/PSG performed the preceding night.

Special Instructions:_____

_____

Scheduling: Contact patient with appointment _____ **Contact office with appointment** _____

Signature of Ordering Physician:_____ **Date/Time:**_____

Please include a recent History and Physical

WNJ