Regional Health Diagnostics. Inc.

ACHC Accredited Procedure Order Form

Fayetteville Office

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Lumberton Office

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Please circle: **Neuro Consult/Testing** **Neuro Testing Only** **Sleep Consult/Testing** **Sleep Testing Only** **Sleep/Neuro Consult**

Patient Name: ____ Date: ____________________

Address:____

Home Phone: ______________________________ SSN#: ______________________________

DOB: __________ Age: __________ Gender: Male Female **ESS**: ________ (Epworth Sleepiness Score – for Sleep Pts)

Height: ________ **Weight**:________ **BMI**: ________ **Neck Cir**: ________

EEG Study(s) Req: ☐ Routine EEG Recording ☐ Long term Video EEG ☐ Ambulatory Video EEG 24 Hr ____48 Hr ___ 72 Hr ___

Reason(s) for EEG:

_____ CVA-h/o CVA
_____ CHF-h/o CHF
_____ High Blood Pressure
_____ Headaches
_____ Seizures /Epilepsy
_____ Pulmonary HTN
_____ Heart Disease
_____ Ischemic Heart Disease
_____ Conversion Disorder

Suspected Diagnosis:____

Sleep Study(s) Req:

☐ PSG/CPAP Titration
☐ CPAP Titration (In-Lab)
☐ HST (Home Sleep Test)
☐ **HST OK IF PSG DENIES?**
☐ Split Night Study (If Severe OSA > 40/hr and 02 desat <85%)
☐ MSLT/MWT
☐ PSG/MSLT
☐ PSG only (In-Lab)

Reason(s) for Sleep Testing:

_____ Snoring
_____ Obesity
_____ Gasping/Choking
_____ Witnessed Apneas
_____ Restless Leg
_____ Sleep Disturbance
_____ History of OSA
_____ History of Narcolepsy
_____ Excessive Daytime Sleepiness
______ Complex Sleep Apnea
______ Central Sleep Apnea
______ Parasomnias

Do any of these Co-Morbities apply?

_____ Impaired cognition/dementia
_____ Unexplained pulmonary hypertension
_____ Moderate to severe congestive heart failure
_____ Moderate to severe pulmonary disease – If so, *PFT/Blood Gas Test Results*: ______________________
______ Diagnosed significant acute cardiac arrhythmia
______ Known neurodegenerative disease
______ Uncontrolled seizure disorder
______ Stroke (CVA)

Other: ____

Results of Previous Sleep Study: _____________________________ **Have Report? Y / N**

Please include: ***Physician Notes Supporting Need of Study*** ***Copy of Insurance Card*** ***Patient Demographics**

Referring Physician: ______________________________ Facility: ____________________________

Address: ____

Phone: _____________________ Fax: ____________________ NPI #: ______________________

Referring Physicians Signature: ______________________________________ Date: ______________