Regional Health Diagnostics. Inc. ACHC Accredited Procedure Order Form

☐ **Jacksonville Office**	☐ **New Bern Office**	☐ **Kinston Office**	☐ **Wilmington Office**	☐ **Havelock Office**
38 Office Park Drive	2922 Trent Road	1136 Hwy 258, Ste 102A	3806 Peachtree Avenue	331 W Main St, Ste C
Jacksonville, NC 28546	New Bern, NC 28560	Kinston, NC 28504	Wilmington, NC 28403	Havelock, NC 28532
P: (910) 333-8947	P: (252) 635-9822	P: (252) 686-5044	P: (910) 399-1413	P: (252) 444-1461
F: (910) 333-1266	F: (252) 635-1822	F: (252) 686-5047	F: (910) 399-1415	F: (252) 444-1509

☐ **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 _____ Headaches _____ Heart Disease
_____ CHF-h/o CHF _____ Seizures /Epilepsy _____ Ischemic Heart Disease
_____ High Blood Pressure _____ Pulmonary HTN _____ 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 _____ Witnessed Apneas _____ History of OSA ______ Complex Sleep Apnea
_____ Obesity _____ Restless Leg _____ History of Narcolepsy ______ Central Sleep Apnea
_____ Gasping/Choking _____ Sleep Disturbance _____ Excessive Daytime Sleepiness ______ Parasomnias

Do any of these Co-Morbities apply? PLEASE NOTE: In-Lab Studies Usually Require a Co-Morbidity for Approval

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

Other: (Please be specific)____

Patient had a Previous Sleep Study? Y/N Results: ________________________________ **Report Provided? Y / N**
If currently on CPAP, provide recent compliance report and reason for new sleep study: ____________________

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:** ______________