Regional Health Diagnostics. Inc.

ACHC Accredited Procedure Order Form

Winterhaven, FL Office

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ACHC ACCREDITED

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

_____ 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: _____

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: _____