Regional Health Diagnostics. Inc.

ACHC Accredited   Procedure Order Form

☐ **Jacksonville Office**
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☐ **Havelock Office**
331 W Main St, Ste C
Havelock, NC 28532
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Patient Name: ____ Date: __________________

Address:____

Home Phone: ___________________________________ SSN#: ___________________________________

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

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

☐ **Neuro Consult/Testing**   ☐ **Neuro Testing Only**   ☐ **Sleep Consult/Testing**   ☐ **Sleep Testing Only**   ☐ **Sleep/Neuro Consult**

EEG Study(s) Req:

☐ Routine EEG Recording   ☐ Ambulatory Video EEG 48 Hr ___ 72 Hr ___
☐ 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? 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: ______________