Regional Health Diagnostics. Inc.

ACHC Accredited Procedure Order Form

❑ **JACKSONVILLE**
38 Office Park Drive
Jacksonville, NC 28546
P: 910.333.8947 | F: 910.333.1266

❑ **NEW BERN**
2922 Trent Road
New Bern, NC 28562
P:252.635.9822 | F: 252.635.1822

❑ **HAVELOCK**
331-C West Main Street, Ste. C
Havelock, NC 28532
P: 252.444.1461 | F: 252.444.1509

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) Reg:

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

Suspected Diagnosis:

Sleep Study(s) Reg:

☐ 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? 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:** _____

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Procedure Order Form - RR

❑ **Fayetteville Office**
345 Denvers Street, Suite 102
Fayetteville, NC 28303
P: (910) 491-0117
F: (910) 491-0166

❑ **Lumberton Office**
405 West 27th Street
Lumberton, NC 28358
P: (910) 536-1479
F: (910) 536-1527

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❑ **Neuro Consult/Testing** ❑ **Sleep Consult/Testing**

Please include: ❑ **Doctors's Notes Supporting Need of Study** ❑ **Copy of Insurance Card** ❑ Patient's Demographics

Patient Name: _____ Date: _____
Address: _____
Home Phone: _____ SS#: _____
Emergency Contact Name/Phone: _____
DOB: _____ Age: _____ Weight: _____ Height: _____ Gender: ❑ Male ❑ Female
Primary Insurance: _____ Policy/Grp#s: _____
Secondary Insurance: _____ Policy/Grp#s: _____
Insurance Holder's Name: _____ Insurance Holder's DOB: _____
Relationship to Patient: _____ Insurance Holder's SS#: _____
Occupation: _____

Medical Conditions: ❑ Diabetes ❑ Obesity ❑ CVA ❑ Chronic Pain ❑ Asthma /COPD ❑ TIA
❑ High Blood Pressure ❑ CHF ❑ Epilepsy ❑ ALS ❑ Fibromyalgia ❑ Heart Disease ❑ GERD

Symptoms: ❑ Confused/Disoriented ❑ Snoring ❑ Witnessed Apneas ❑ EDS (Exessive Daytime Sleepiness)
❑ Leg or Kicking Movement ❑ Restless Legs ❑ Gasping/or Choking

Reason for study:
❑ Sleep Disturbance
❑ Pulmonary HTN
❑ Known h/o Obstructive Sleep Apnea
❑ h/o CVA (Ischemic Cerebrovascular disease)
❑ Hypersomnia/ Excessive Daytime Sleepiness
❑ Unspecified Sleep Apnea
❑ h/o Narcolepsy (order MSLT)
❑ IHD (Ischemic Heart disease)
❑ HTN
❑ Seizures ❑ h/o CHF
❑ Headaches

Diagnosis: _____

Study Requested:
❑ PSG/CPAP Titration
❑ HST (home Sleep Test)/CPAP Titration
❑ Split Night Study (If Severe OSA > 40/hr and 02 desat <85%)
❑ CPAP Titration
❑ MSLT/ MWT
❑ Routine EEG Recording
❑ Long term Video EEG
❑ Ambulatory EEG
24 Hr ____48 Hr ___ 72 Hr ___

Additional Orders:
❑ Consult- This is a request to have interpreting physician review positive tests, orders any additional tests, and arrange for sleep related follow up care.

Referring Physician: _____
Facility: _____
Address: _____
Phone: _____ Fax: _____ NPI #: _____
Referring Physicians Signature: _____ Date: _____

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❑ **Kernersville Office**
495 Arbor Hill, Suite G
Kernersville, NC 28284
P: (336) 993-8448
F: (336) 993-8483

❑ **Johnson City, TN Office**
329 Wesley Street, Suite 3
Johnson City, TN 37601
P: (423) 610-0020
F: (615) 691-6177

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❑ **Neuro Consult/Testing** ❑ **Sleep Consult/Testing**

Please include: ❑ **Doctors's Notes Supporting Need of Study** ❑ **Copy of Insurance Card** ❑ Patient's Demographics

Patient Name: _____ Date: _____
Address: _____
Home Phone: _____ SS#: _____
Emergency Contact Name/Phone: _____
DOB: _____ Age: _____ Weight: _____ Height: _____ Gender: ❑ Male ❑ Female
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