Regional Health Diagnostics. Inc.

ACHC Accredited Procedure Order Form

Columbus, Georgia Office

500 18th St., Suite A-10
Columbus, GA 31904
P: (706) 221-9291
F: (706) 221-9317

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:** _______________