Regional Health Diagnostics. Inc.

ACHC Accredited Procedure Order Form

❑ FAYETTEVILLE
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Fayetteville, GA 30214
P: 678.489.8605 | F: 678.866.2374

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%)
☐ Oral Dental Appliance Tx
☐ 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
_____ 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: (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:** _____