Regional Health Diagnostics. Inc.

ACHC Accredited Procedure Order Form

☐ COLUMBUS
500 18th St., Ste. A-10
Columbus, GA 31904
P: 706.221.9291 | F: 706.221.9317

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

Suspected Diagnosis:

Sleep Study(s) Reg:

☐ PSG 95810/CPAP Titration 95811 ☐ HST OK IF PSG DENIES? G0399 ☐ 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)
☐ Oral Dental Appliance Tx

Reason(s) for Sleep Testing:

☐ Snoring R06.83 ☐ Witnessed Apneas G47.30/ Sleep Apnea Unspecified ☐ History of OSA, Adult/Pediatric G47.33 ☐ Sleep Deprivation Z72.820 ☐ Insomnia F51.04
☐ Obesity E66.01 ☐ Complex Sleep Apnea
☐ Gasping/Choking ☐ Restless Leg ☐ History of Narcolepsy ☐ Central Sleep Apnea
☐ Sleep Disturbance ☐ Hypersomnia G47.10 ☐ 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? ☐ Yes ☐ No Results: _____ **Report Provided? ☐ Yes ☐ No**

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:** _____