# Regional Health Diagnostics. Inc.

ACHC Accredited Procedure Order Form


❑ JACKSONVILLE
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❑ NEW BERN
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❑ 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:** _____

***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 95810/CPAP Titration 95811
❑ CPAP Titration (In-Lab)
❑ HST (Home Sleep Test)
❑ HST OK IF PSG DENIES? G0399
❑ 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 R06.83
____ Obesity E66.01
____ Gasping/Choking
____ Witnessed Apneas G47.30/ Sleep Apnea Unspecified
____ Restless Leg
____ Sleep Disturbance
____ History of OSA, Adult/Pediatric G47.33
____ History of Narcolepsy
____ Hypersomnia G47.10
____ Sleep Deprivation Z72.820
____ Complex Sleep Apnea
____ Central Sleep Apnea
____ Parasomnias
____ Insomnia F51.04

**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? ❑ Yes ❑ No Results:** _____ **Report Provided? ❑ Yes ❑ No**

**If currently on CPAP, provide recent compliance report and reason for new sleep study:** _____

**Additional Orders:**

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

**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:** _____