SLEEP DISORDERS CENTER
POLYSOMNOGRAPHY REQUEST

North Shore – Long Island Jewish Health System

155 Community Drive, Great Neck, NY 11021
Sleep Disorders Center (516) 465-8270

REFERRING PHYSICIAN:

MD Name:_____ **Specialty:** _____

MD Office Address:_____ **City**_____ **State**____ **Zip**_____

Office Telephone:_____ **Fax:** _____

PATIENT INFORMATION: ***(Attach copy of insurance card, both front and back)***

Patient Name:_____ **Sex:** M / F **Insurance Carrier:** _____

Address:_____ **Insurance ID:** _____

City, State, Zip:_____ **Phone:**_____ **Date of Birth:**_____

CLINICAL HISTORY & INDICATIONS: ***(Please attach latest history and physical.)***

History: __Excessive daytime somnolence __Obesity/recent weight gain __Hypertension
__Heavy snoring __Early morning headache __Cardiovascular disease: _____
__Witnessed apneic episodes __ **Handicap Accessibility/Special Needs--Reason**: _____
Previous sleep study: ___Yes ___No Findings:_____

At NSLIJ: ___Yes ___No _____

Physical Exam: Wt. ___ Ht.____ BP_____ ENT findings: __Crowded oropharynx __Enlargement of soft palate/uvula
__Tonsilar hypertrophy __Other:_____
Other significant physical findings:_____

Suspected: __Sleep apnea __Narcolepsy
__Periodic leg movement disorder __Other:_____

Medications: _____
Comments: _____

******To request a consultation with a sleep medicine physician, please check here:*** _____
For Consultation/Office Visits call (516) 465-3899

Ordering Physician:_____ **Signature:**_____ **Date:** _____

PHYSICIAN ORDERS:

Initial Dx:_____ ICD:_____ SDC Physician Signature:_____

Test ordered: _____Diagnostic Polysomnogram (95810) _____Home Sleep Study Diagnostic (95806)
_____CPAP/BiLEVEL TITRATION Polysomnogram (95811) _____Home AutoPAP (G0400)
_____SPLIT Diagnostic/Therapeutic Polysomnogram (95811)
_____Multiple Sleep Latency Test (95805) _____Maintenance of Wakefulness Test (95805)

Instructions to Polysomnographic Technologist (special patient or study requirements):_____
_____

SCHEDULING /PREAUTHORIZATION:

Tentative date: _____ Packet sent: _____
Contacted Carrier: _____ Date _____ Appt. Confirmed: _____
(Name of contact) By: _____
Faxed med nec./notes: _____ PREAUTHORIZATION NUMBER: _____
Pt. Resp./Co-pay:_____ BY: _____
Secretary's Initials

Please fax to: (516) 465-8299