SLEEP STUDY PRESCRIPTION FORM

Tel: 626.281.6200 Fax Order: 626.281.3132

880 S. Atlantic Blvd., Suite 300, Monterey Park, CA. 91754

"Copies of all Insurance Cards and Relevant Clinical Notes must be Faxed with order to expedite processing"

www.remsleepdiagnosticscenter.com

Please print clearly:Patient information

Last Name:_____ First Name _____MI: _____
Address: _____ City_____, CA, Zip _____
Home Phone: _____Cell/Work Phone: _____
Date of Birth _____/_____/_____ Sex: ❑ Male ❑ Female Height:_____ Weight_____

Patient Clinical Information	Reasons for ordering Study (Clinical impressions)
Does the patient have: ❑ Hypertension ❑ CHF ❑ Cardiac Arrhythmia ❑ Other: _____ Does patient require oxygen? ❑ No ❑ Yes _____LPM What are the patients's known allergies? What are the patient's current medications?	❑ Excessive Daytime Sleepiness ❑ Snoring ❑ Obstructive Sleep Apnea ❑ Insomnia ❑ Restless Legs Syndrome ❑ Narcolepsy ❑ Periodic Limb Movements ❑ Sleepwalking ❑ Strange Behaviors During Sleep ❑ Sleeptalking ❑ Other or Undetermined

Referring Physician	Consult or Sleep Study Ordering
Physician: _____Specialty_____ Tel ( ) _____Email: _____ Address: _____ City: _____State: _____ Zip _____ Fax: ( ) _____ Office Contact: _____Date of this Order: _____	❑ Diagnostic Polysomnography (PSG) 95810 ❑ CPAP Titration / Trial with CPAP 95811 ❑ Split Night Polysomnography 95811 ❑ Multiple Sleep Latency Test (MSLT) 95805 ❑ MSLT/ Multiple Wakefulness Test (MWT) daytime test R/O narcolepsy (conducted morning after PSG) 95810 ❑ Other:

Physician Signature: _____ Date: _____

UPIN# _____DEA# _____