



# Sleep Testing Order Form

Phone: (303) 396-5923

Fax: (303) 957-5414

*If ordering using your EMR please use this as a guide for verbage, CPT Codes and required documentation.*

<b>Brighton</b> 191 Telluride St	<b>Broomfield</b> 3301 W 144 Ave	<b>Colorado Springs - AB</b> 1849 Austin Bluffs Pkwy	<b>Colorado Springs - LP</b> 1235 Lake Plaza Dr	<b>Denver</b> 1210 S Parker Rd	<b>Littleton</b> 8151 Southpark Ln	<b>Longmont</b> 2350 17th Ave
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**Patient Name:**

**Date of Birth:**

**Guardian Name (if minor):**

**Phone:**

☐ **New Order:** Please check if this order is not a direct response to a test we've completed in the past 3 months.

☐ **Return Order:** Please check if this order is a direct response to a test we've completed in the past 3 months.

## COMPREHENSIVE CARE FOR ADULTS & PEDIATRIC PATIENTS 6 AND OLDER

REQUIRED DOCUMENTATION: Signed & Dated Order ○ Face to Face Visit Notes With Ordering Reason ○ Patient Demographics

☐ **Split Night Study with Follow-up Clinic Consult** 95811 (Mountain Sleep will follow-up with the patient and order equipment or further testing as needed. Patient may do a Home Sleep Study 95800, if required by insurance )

## SPECIFIC TESTING FOR ADULTS & PEDIATRIC PATIENTS 6 AND OLDER

REQUIRED DOCUMENTATION: Signed & Dated Order ○ Face to Face Visit Notes With Ordering Reason ○ Patient Demographics

☐ **Split Night Study** 95811 (or may do a Home Sleep Study 95800, if required by insurance )

☐ **Home Sleep Study** 95800 - *Only patients 18 or older*

☐ **Baseline NPSG Only** 95810

☐ **Titration Study** 95811 (Requires copy of previous Sleep Study and if patient is on PAP therapy, copy of Compliance/Data Download Report)

☐ **MSLT** 95805 (Only if night study is negative for OSA) **Select Night Study:** ☐ **Baseline** 95810 ☐ **Split** 95811 ☐ **Titration** 95811

☐ **Home Nocturnal Pulse Oximetry** 94762 **Select Mode:** ☐ Room Air ☐ CPAP ☐ Supplemental Oxygen ☐ Oral Appliance

## SLEEP CONSULTATIONS WITH ONE OF OUR PROVIDERS

☐ **Sleep Clinic Consult - Post-Test** (Select a test above and we will follow-up with patient, order equipment or testing as needed)

☐ **Sleep Clinic Consult - Pre-Test** (We will see the patient first and then we will order tests & equipment, as needed)

## SPECIAL REQUESTS

☐ **Seizure Montage**

☐ **RBD Montage**

☐ **Altitude Testing** (Select if patient's lives at high altitude and thereby at greater risk for Central Sleep Apnea)

## SUSPECTED DISORDERS AND RELEVANT SLEEP HISTORY (Check all that apply)

☐ Obstructive Sleep Apnea (G47.33)

☐ Other Sleep Apnea (G47.39)

☐ Central Sleep Apnea (G47.31)

☐ Unspecified Sleep Apnea (G47.30)

☐ Sleep Related Hypoventilation (G47.36)

☐ Other: \_\_\_\_\_

☐ Hypersomnia (G47.10)

☐ Narcolepsy w/ Cataplexy (G47.411)

☐ Narcolepsy w/o Cataplexy (G47.419)

☐ Night Terrors (F51.4)

☐ Periodic Limb Movement Disorder (G47.61)

☐ Previous Sleep Study? Date: \_\_\_\_\_

Provider's Signature:

Date:

Provider's Name (Print):

NPI:

Office Phone:

Office Fax:

Contact Name:

Fax with required documentation to: 303-957-5414