

SHANDS SLEEP DISORDERS CENTER  
352-265-5240 PH 352-265-5241 FAX  
4740 NW 39 PLACE, SUITE C, GAINESVILLE, FL 32606

POLYSOMNOGRAPHY ORDER

DATE: \_\_\_\_\_ MR#-UF: \_\_\_\_\_ APPOINTMENT DATE & TIME: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ PARENT/GUARDIAN NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP \_\_\_\_\_

DOB: \_\_\_\_\_  FEMALE  MALE

HOME PHONE # \_\_\_\_\_ WORK PHONE # \_\_\_\_\_

SLEEP DISORDER SYMPTOMS: (MUST BE MARKED) DATE OF ONSET: \_\_\_\_\_

- BODY JERKING/RESTLESS LEGS  FREQUENT AWAKENINGS  CHOKES/GASPS/STOPS BREATHING  
 SNORES  EXCESSIVE DAYTIME SLEEPINESS  VIOLENT BEHAVIOR DURING SLEEP  
 OTHER \_\_\_\_\_ HT \_\_\_\_\_ WGT \_\_\_\_\_

PLEASE SELECT TEST TO BE PERFORMED BCBS PROV # - 125 AETNA PROV # - 0009192

- Split night – both Diagnostic and Titration the same night, if lab criteria are met within time limit (2am) (95811)  
 Diagnostic Sleep Study only (95810)  If needed schedule to return for positive pressure titration (CPAP)  
 Positive Pressure CPAP titration/Retitration only (95811)  
 MSLT (95805) (to follow sleep study the morning after overnight diagnostic study)  
 Collect Urinalysis tox screen for MSLT

Diagnosis:  OSA (327.23:327.20)  Narcolepsy (347.0)  Periodic Leg Movement Disorder (327.51)  
Other: \_\_\_\_\_ Special request for study: \_\_\_\_\_

Medical  Behavioral  Latex Allergy  O2 required  Atrial Fib  
 CHF/Angina  Mentally Impaired  Pacemaker  \_\_\_\_\_  
Alert  COPD  Non-Ambulatory  Seizures  \_\_\_\_\_

MD REMINDER: If patient is to use a sleep medication, (Ambien, Lunesta, etc) please send it with your patient.  
Caregivers must be present during study for minors and patients with physical disabilities/limitations.

Attending MD (print): \_\_\_\_\_ Attending MD Signature: \_\_\_\_\_  
Attending MD Service: \_\_\_\_\_ Attending MD NPI: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Phone # \_\_\_\_\_ Contact Name: \_\_\_\_\_  
Fax # \_\_\_\_\_ Contact Ext: \_\_\_\_\_

**\*\*RECENT HISTORY AND PHYSICAL MUST BE AVAILABLE IN SHANDS SYSTEM OR ATTACHED TO THIS FORM. SLEEP DISORDER SYMPTOMS MUST BE NOTED ABOVE. INCOMPLETE REQUESTS WILL NEED TO BE RETURNED UNPROCESSED.**

Guarantor  Patient  If guarantor is not the patient, please fill in all info below  
OR  Parent Name \_\_\_\_\_  
Subscriber  Spouse DOB \_\_\_\_\_ SS# \_\_\_\_\_

If under age 18, must list parent as guarantor, or subscriber, including Medicaid and CMS recipients.  
MEDICARE PATIENT? If yes, must provide \*\* Retirement/Disability Mo/Day/Yr \_\_\_\_/\_\_\_\_/\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Authorization # \_\_\_\_\_ Exp. Dt \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Authorization # \_\_\_\_\_ Exp. Dt \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_