Chestnut Hill Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

Sleep Study Order Form

8835 Germantown Ave
Philadelphia, PA 19118
Phone: 215-248-8400
Option 2 then Option 8
Fax: 215-753-2011

Patient Information

Name:_____ DOB:_____/_____/_____ Date:_____/_____/_____

Phone:_____ Cell:_____ Email:_____ ☐ M ☐ F

Address:_____ City:_____ St:____ Zip:_____

Primary Insurance:_____ ID#: _____ MR#:_____

Referring Physician Information

Referring Physician:_____ Office Contact: _____

Address:_____ City:_____ St:_____ Zip:_____

Phone:_____ Fax:_____ NPI#:_____

Check the symptoms that best describe the patient's sleep complaint

- ☐ Loud Snoring/Disrupted Sleep
- ☐ Witnessed Apnea
- ☐ Nocturnal Choking/Gasping
- ☐ Daytime Hypersomnolence
- ☐ Non-Refreshing Sleep
- ☐ Drowsy Driving
- ☐ Morning Headaches
- ☐ Sleep Paralysis
- ☐ Leg Jerks or Restless Legs

Medical History

- ☐ Hypertension
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation/SVT
- ☐ Neuromuscular Impairment
- ☐ Obesity
- ☐ Parkinson's Disease
- ☐ Acute Epilepsy
- ☐ History of Stroke
- ☐ Cognitive Impairment
- ☐ Previously diagnosed with OSA
- ☐ COPD
- ☐ Asthma
- ☐ Pulmonary Hypertension
- ☐ Oxygen Dependent
- ☐ Diabetes

Indication for study

- ☐ Periodic Limb Movement Disorder (G47.61)
- ☐ OSA (G47.33)
- ☐ Central Sleep Apnea (G47.31)
- ☐ Narcolepsy (G47.419)
- ☐ Other: _____

Physician Order

- ☐ NPSG and Titration- Titration study performed upon recommendation in interpretation
- ☐ NPSG-Diagnostic Sleep Study
- ☐ Split Night Study- CPAP Titration is initiated according to AASM Guidelines
- ☐ Titration Study
- ☐ Multiple Sleep Latency Test-preceded by PSG
- ☐ Office Visit- Consultation with Sleep Physician based on documented preferences
- ☐ Home Sleep Test
- ☐ Follow up and treatment by the interpreting physician-Patient's follow up and treatment plan will be based on your current preferences as documented on your Physician Profile Sheet

☐ **I additionally order a home sleep test (HST) for the patient if (1) it is required by the patient's insurance company or (2) There is insufficient clinical information for an attended sleep study.**

I certify: That this service is medically necessary. The information provided is true, accurate and documented in the patient's clinical notes.

Physician Signature:_____ Date:_____

Fax this order, clinical notes and insurance information to: 215-753-2011