



Falcon Sleep Center

120 Alexandria Blvd, Suite - 19

Oviedo, FL 32765

Tel #: 407-365-3033



EIN: 11-3812755

NPI: 1700078979

Polysomnography Medical Request Form

Fax back to: 407-365-3034

Patient

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Any significant medical history? Yes No

If Yes, please specify: _____

Suspected Diagnosis (Check appropriate boxes):

- | | |
|--|---|
| <input type="checkbox"/> Obstructive Sleep Apnea (OSA) | <input type="checkbox"/> REM Behavior Disorder |
| <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Restless Legs/Periodic Limb Movement Disorder | <input type="checkbox"/> Hypersomnia ICD-9 Code: _____ |
| <input type="checkbox"/> Morbid Obesity | <input type="checkbox"/> Other (specify) _____ |

Sleep History/Symptoms (Check appropriate boxes):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Snoring | <input type="checkbox"/> Muscle/joint aches | <input type="checkbox"/> Wakes up choking |
| <input type="checkbox"/> Witnessed apneas | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent nightmares |
| <input type="checkbox"/> Difficulty initiating sleep | <input type="checkbox"/> Impotence | <input type="checkbox"/> Cataplexy | <input type="checkbox"/> s/p surgery for OSA |
| <input type="checkbox"/> Morning headaches | <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Sleep paralysis | |
| <input type="checkbox"/> Nocturnal teeth grinding | <input type="checkbox"/> Acting out dreams | <input type="checkbox"/> Leg movements | |

Relevant Medical History (Check appropriate boxes):

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> CHF | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> Pulmonary hypertension | <input type="checkbox"/> CAD | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Anxiety disorder |
| <input type="checkbox"/> Pulmonary disease | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Claustrophobic | <input type="checkbox"/> Other |
| <input type="checkbox"/> Arrhythmia (VT/Afib) | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Latex allergies | |

Previous Sleep Study? **Y N** If yes, where? _____ when? _____

Sleep Study Requested (Check appropriate boxes):

- Overnight Polysomnography (CPT: 95810)
- Positive Airway Pressure (CPAP) Titration (CPT: 95811)
- Combined Overnight Polysomnography and CPAP Titration (Split Night Study) (CPT: 95811)
- Narcolepsy Screen (Overnight Polysomnography followed by MSLT)
- Multiple Sleep Latency Test (MSLT)

Supplemental oxygen will be administered when indicated and as referring physician, you will be notified.

- Authorization for Ambien or other sleep aid at bedtime.** (Patient Brings Medication)

Physician Name: _____ UPIN #: _____

Signature: _____

Specialty: Pulmonary Neurology ENT Cardiology Internal Medicine Family Practice Other (please specify): _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Contact Person: _____

Phone: _____ Fax: _____

PLEASE ATTACH/FAX PATIENT DEMOGRAPHICS
(Include Insurance Card and brief H&P relating to their possible sleep disorder)