The Good Shepherd Sleep Center LLC
13668 W Hillsborough Ave
Tampa, FL 33635
P 727.807.6969 **F** 727.400.3292

Patient Name:____SSN:______________________

Address____DOB: ______________________
City____State______Zip______________
Phone (____)________________________ Alternate Phone (____)________________________
Height_______ Weight ________ BMI _____ Neck Circumference_________ ESS __________
**** Please fax a copy of the patient's insurance card.**
Please Send: □ History and Physical □ Current Office Notes (to warrant sleep study)
Above Required for: Medicare, RR Medicare, CHAMPUS, TRICARE, and BCBS

Section A: Reason for Consult or Study: Please check at least <u>TWO</u> that apply:
Symptoms:

□ Witnessed Apnea	□ Excessive Daytime Sleepiness	□ Impaired Cognition
□ Loud Snoring	□ Sleep disturbance	□ Reflux
□ Fatigue	□ Depression	□ Morning Headache
□ Obesity	□ Memory Loss	□ Nocturia

Medical History:

□ Hypertension	□ Congestive heart failure	□ Seizures
□ Coronary heart disease	□ Neuromuscular disease	□ Diabetes
□ Cerebrovascular disease	□ COPD	□ Other

Is patient on Oxygen? Yes No LPM? ______
If yes, do you want patient on oxygen from the beginning of the study? ___________________________

Section B: Diagnostic Codes: Please check only <u>ONE</u> that applies:

□ 327.23 Obstructive Sleep Apnea	□ 307.46 Sleep Arousal Disorder (Parasomnia)
□ 780.54 Other Hypersomnia-Excessive Daytime Somnolence	□ 780.51 Insomnia with Sleep Apnea
□ 780.57 Other and Unspecified Sleep Apnea	□ 780.53 Hypersomnia with Sleep Apnea
□ 347.00 Narcolepsy*	

* **(This diagnosis requires a Polysomnogram, followed by daytime multiple sleep latency testing)**

Section C: Sleep Study Type:

□ 95810	Diagnostic Polysomnogram
□ 95811	Polysomnogram with CPAP (overnight treatment study)
□ 95811	Split Night Study if criteria met
□ 95810/95805	Diagnostic Polysomnogram followed by MSLT
□ 95810/95805	PAP-NAP Compliance procedure
□ G0398	HST Home Sleep Study

Section D: Physician Only
Signing this form indicates a clinical evaluation was completed and met the Medicare required guidelines.

Physician Signature:____
Physician Name (Printed):____
Interpreting Physician (if requested):____
Phone:____Fax_____________________________