SLEEP CENTER HAWAII

REQUISITION FORM FOR
SLEEP STUDY SERVICES

AASM ACCREDITED Facility Member℠

☐ **Kailua-Kona**
75-167 Kalani St #205, Kailua-Kona HI 96740
(808) 32-SNOOZ (327-6669)
Fax to: (808) 327-4506

☐ **Aiea Medical Center**
99-128 Aiea Hts Dr #101, Aiea, HI 96701
(808) 456-REST (7378)
Fax to: (808) 483-8822

☐ **Hilo**
56 Kamehameha Ave, Hilo, HI 96720
(808) WOW-REST (969-7378)
Fax to: (808) 969-8189

PATIENT INFORMATION:

Name: _____ Date of Birth: _____/_____/_____

Address: _____

Home Phone: _____ Cell Phone: _____ E-mail Address: _____

INSURANCE INFORMATION: *Please obtain prior authorization from insurance carrier if applicable.*

Insurance Carrier: _____ Member#: _____ Auth#: _____

Responsible Party name: _____ Responsible Party DOB: _____/_____/_____

REFERRING PROVIDER: _____ Specialty: _____ POC: _____

Address: _____ Phone: _____ Fax: _____

CC: Physician: _____ Fax: _____

TYPE OF SERVICE REQUESTED: *Please check at least one box before submitting.*

☐ 1. **REFERRAL TO SLEEP CLINIC** for initial consult, evaluation, treatment, and follow-up as needed
☐ 2. **BASELINE SLEEP STUDY** (Video-Polysomnography; Diagnostic, overnight test) CPT 95810
☐ 3. **SPLIT NIGHT SLEEP STUDY** (Video-Polysomnography**;** Combined diagnostic/CPAP trial; overnight test) CPT 95811
☐ 4. **CPAP/BiPAP TITRATION** (Video-Polysomnography; Continuous Positive Airway Pressure trial; overnight test) CPT 95811
☐ 5. **MSLT/MWT** Multiple Sleep Latency Test /Maintenance of Wakefulness Test (Daytime nap study) CPT 95805
☐ 6. **HOME SLEEP STUDY** CPT 95806
☐ 7. **CPAP/BiPAP (DURABLE MEDICAL EQUIMENT "DME")** dispense requested for PAP device, "interface", mask, and accessories as needed

SUSPECTED SLEEP DIAGNOSIS: ☐ **Obstructive Sleep Apnea** ☐ **Other:** _____

Duration of Symptoms: _____ Medical Hx: _____

Ambulatory Patient: ☐ Yes ☐ No Requires Personal Assistance: ☐ Yes ☐ No

PLEASE CHECK ALL THAT APPLY:

☐ Apnea Observed	☐ Retrognathia / Micrognathnia	☐ Fragmented Sleep
☐ Snoring	☐ Difficulties w/ current CPAP/BiPAP	☐ Non-Restorative Sleep
☐ Gasping at night	☐ Hypertension	☐ Insomnia
☐ Choking	☐ Cardiac Arrhythmias	☐ Unusual or violent nocturnal movement
☐ Excessive Daytime Somnolence	☐ Heart Failure	☐ REM behavior disorder ("Dream Enactment")
☐ Positive "STOP BANG" Screen	☐ Diabetes	☐ Sleep walking/talking
☐ Small Oropharyngeal opening	☐ Hypercholesterolemia	☐ Restless Legs/Periodic Limb Movements
☐ Mallampati grade 1, 2, 3, 4	☐ Morning Headaches	☐ Depression
☐ Enlarged tongue	☐ Nocturia	☐ Anxiety
☐ Short/thick neck	☐ Erectile dysfunction	
☐ Enlarged tonsils	☐ Post Stroke	**CHILDREN (2 Yrs+)**
☐ Neck circumference	☐ Nocturnal Seizure	☐ Snoring
> 17 in males, > 16 in females	☐ Asthma/COPD	☐ Failure to grow
☐ Recent Weight Gain ___ lbs	☐ O2 at ____L/min	☐ ADHD
☐ Metabolic Syndrome	☐ Bruxism	☐ Craniofacial Abnormalities / Genetic Syndrome

SYMPTOM LIST FOR HMSA/HMAA PATIENTS *("CHEAT SHEET"; if any of these present, patient will qualify for "in Lab" sleep study)*

☐ Chronic Insomnia	☐ COPD/Asthma with pCO2 >45 mmHg	☐ Restless Legs/Periodic Limb Movements
☐ Teeth grinding (Bruxism)	☐ Pulmonary Hypertension	☐ Unusual or violent nocturnal movement
☐ Obesity BMI > 45	☐ CHF Class III/IV; LVEF < 45%	☐ REM behavior disorder ("Dream Enactment")
☐ Obesity hypoventilation syndrome	☐ Narcolepsy/Cataplexy	☐ Sleep walking/talking
☐ BMI >35 and unable to lie flat	☐ Neuromuscular disorder	
☐ BMI >35 with pCO2 >45mmHg	☐ Intellectual disability/mental illness	☐ Child under age 18

Age:	**BP:**	**Pulse:**	**Ht:**	**Wt:**	**BMI:**	**Gender:**	☐ Adult ☐ Child

Referring Provider signature: **Reviewed by Sleep Specialist:**