Sleep Testing Order Form

Mountain Sleep Diagnostics

Phone: (303) 396-5923 Fax: (303) 957-5414

If ordering using your EMR please use this as a guide for verbage, CPT Codes and required documentation.

Brighton	Broomfield	Colorado Springs - AB	Colorado Springs - LP	Denver	Littleton	Longmont
191 Telluride St	3301 W 144 Ave	1849 Austin Bluffs Pkwy	1235 Lake Plaza Dr	1210 S Parker Rd	8151 Southpark Ln	2350 17th Ave

Patient Name: **Date of Birth:**

Guardian Name (if minor): **Phone:**

☐ New Order: Please check if this order is not a direct response to a test we've completed in the past 3 months.

☐ Return Order: Please check if this order is a direct response to a test we've completed in the past 3 months.

COMPREHENSIVE CARE FOR ADULTS & PEDIATRIC PATIENTS 6 AND OLDER

REQUIRED DOCUMENTATION: Signed & Dated Order ○ Face to Face Visit Notes With Ordering Reason ○ Patient Demographics

☐ **Split Night Study with Follow-up Clinic Consult** 95811 (Mountain Sleep will follow-up with the patient and order equipment or further testing as needed. Patient may do a Home Sleep Study 95800, if required by insurance)

SPECIFIC TESTING FOR ADULTS & PEDIATRIC PATIENTS **6 AND OLDER**

REQUIRED DOCUMENTATION: Signed & Dated Order ○ Face to Face Visit Notes With Ordering Reason ○ Patient Demographics

☐ **Split Night Study** 95811 (or may do a Home Sleep Study 95800, if required by insurance)

☐ **Home Sleep Study** 95800 - *Only patients 18 or older*

☐ **Baseline NPSG Only** 95810

☐ **Titration Study** 95811 (Requires copy of previous Sleep Study and if patient is on PAP therapy, copy of Compliance/Data Download Report)

☐ **MSLT** 95805 (Only if night study is negative for OSA) ***Select Night Study:*** ☐ **Baseline** 95810 ☐ **Split** 95811 ☐ **Titration** 95811

☐ **Home Nocturnal Pulse Oximetry** 94762 ***Select Mode:*** ☐ Room Air ☐ CPAP ☐ Supplemental Oxygen ☐ Oral Appliance

SLEEP CONSULTATIONS WITH ONE OF OUR PROVIDERS

☐ **Sleep Clinic Consult - Post-Test** (Select a test above and we will follow-up with patient, order equipment or testing as needed)

☐ **Sleep Clinic Consult - Pre-Test** (We will see the patient first and then we will order tests & equipment, as needed)

SPECIAL REQUESTS

☐ **Seizure Montage**

☐ **RBD Montage**

☐ **Altitude Testing** (Select if patient's lives at high altitude and thereby at greater risk for Central Sleep Apnea)

SUSPECTED DISORDERS AND RELEVANT SLEEP HISTORY *(Check all that apply)*

☐ Obstructive Sleep Apnea (G47.33)
☐ Other Sleep Apnea (G47.39)
☐ Central Sleep Apnea (G47.31)
☐ Unspecified Sleep Apnea (G47.30)
☐ Sleep Related Hypoventilation (G47.36)
☐ Other:_____

☐ Hypersomnia (G47.10)
☐ Narcolepsy w/ Cataplexy (G47.411)
☐ Narcolepsy w/o Cataplexy (G47.419)
☐ Night Terrors (F51.4)
☐ Periodic Limb Movement Disorder (G47.61)
☐ Previous Sleep Study? Date:_____

Provider's Signature: Date:

Provider's Name (Print): NPI:

Office Phone: Office Fax:

Contact Name:

Fax with required documentation to: 303-957-5414