FALCON
NEURODIAGNOSTICS & SLEEP

Sleep Study Request Form Fax back to ***407-365-3034*** With Patient's Recent History and Physical	Patients Age 12+ EIN: 11-3812755 NPI: 1700078979 NPI (Consults): 1376741330

☐ **Falcon Oviedo Location** ☐ **Falcon Metrowest Location** ☐ **Patient Choice**

Patient Name: _____ DOB: _____
Address: _____
Home Phone: _____ Work/ Mobile Phone: _____
Insurance: _____ Member ID: _____
Patient Diagnosis: _____ DX Code: _____

Any significant medical history? ☐ Yes ☐ No
If yes, please specify_____

Symptoms (Check all that apply):
☐ **Loud Snoring**
☐ **Excessive daytime sleepiness**
☐ **Witnessed apneas**
☐ **Parasomnias _____**
☐ **Seizures**
☐ **Leg Movements**
☐ **Epworth Sleepiness Score _____**
☐ **Neck Size _____**
☐ **Height _____**
☐ **Weight _____**

Procedures Requested (Please check appropriate boxes):

☐ **Routine PSG (95810)**
☐ **CPAP Titration (95811)**
☐ **Split-Night Study (95811)**
☐ **MSLT (Multiple Sleep Latency Test) (95805)**
☐ **MWT (Maintenance of Wakefulness test) (95805)**
☐ **PAP NAP (95807) (May not be approved by all insurances)**
☐ **Sleep Specialist Consult**
☐ **CPAP Compliance Clinic**
☐ **Routine PSG with extended channel EEG**
☐ **HST (Home Study) (95806 or G0399) (May not be approved by all insurances)**

*** SLEEP STUDY AMBULATORY OPTIONS AVAILABLE ***

Relevant Medical History:

☐ Hypertension ☐ Arrhythmia (VT/Afib) ☐ Stroke Date: _____
☐ Dementia/impaired ☐ Neuromuscular weakness ☐ Tonsillar Hypertrophy
☐ Pulmonary hypertension ☐ CHF (moderate to severe) ☐ COPD
☐ Pulmonary Disease ☐ Asthma ☐ Heart Attack Date: _____

Previous Sleep Study? ☐ Yes ☐ No
If YES, location? _____ **Date:** _____

Physicians Name_____ NPI #: _____ EIN #: _____
Signature: _____

Specialty: ☐ Psychiatrist ☐ Neurologist ☐ Family Practice ☐ Internal Medicine
☐ Other (Please specify): _____

Address: _____Email: _____
City: _____ State: _____ Zip: _____ Contact Person: _____
Phone: _____ Fax: _____

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