SHORE MEDICAL CENTER℠

Healthcare At Its Best

710 Centre St, 2nd Floor,
Somers Point, NJ 08244

FAX: 1-609-477-7037 **PHONE: 1-609-477-7036**

SLEEP STUDY SCRIPT

Patient Name:		Date of Birth:	
Phone:		Alternate Phone:	
Script Date:			

Admitting/Rule-Out Diagnosis:

☐Suspected Sleep Apnea G47.30

☐Diagnosed Obstructive Sleep Apnea G47.33

☐Narcolepsy/Cataplexy G47.419

☐Diagnosed Central/Complex Sleep Apnea G47.37

☐Other:

History of COPD: ☐YES ☐NO
PFT Performed & Attached: ☐YES ☐NO

SLEEP STUDIES

☐PSG (Polysomnogram) 95810
Patients will be split if they meet protocol
☐w/MSLT (Multiple Sleep Latency Test) 95805
☐ w/Seizure Montage

☐MWT (Maintenance of Wakefulness Test) 95805

☐HST (Home Sleep Test) 95806/G0399
Performed when in-lab is denied

☐Against Protocol Split Study 95811

☐CPAP Titration 95811
☐w/MSLT (Multiple Sleep Latency Test) 95805

☐BiPAP Titration 95811

☐AutoSV/Complexity Study 95811
Previous titration study must have at least 50% central apneas + central hypopneas to qualify

☐PAP Nap (PAP Desensitization) 95807

☐PAP Mask Fitting 94660
Mask fittings are included with a PAP NAP

ALL SLEEP RELATED SYMPTOMS MUST BE LEGIBLE/DOCUMENTED IN THE CHART NOTES/OFFICE NOTES

CHART NOTES MUST BE SENT WITH THE SCRIPT TO EXPEDITE TESTING
INCLUDE COPY OF PSG/HSAT IF NOT PERFORMED AT ADVANTAGE

Letter of Medical Necessity

The symptoms checked above are consistent with the presence of a sleep disorder, which could possibly be life threatening. These findings warrant the medical necessity of an overnight polysomnographic evaluation of this patient to assess the presence and severity of the sleep disorder.

Physician's Printed Name:		Physician's Signature:	
Phone:		NPI:	

Please include the following additional information when faxing:

☐ **Completed Script**
☐ **Office Notes –** ***Include Symptoms of Sleep Disorder***
☐ **Patient Demographics & Insurance Card Copies**
☐ **Last PFT** ________________

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