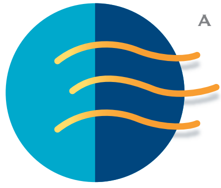

A PARTNERSHIP ST. LUKE'S HOSPITAL • MERCY MEDICAL CENTER • PCI

EASTERN IOWA SLEEP CENTER

600 7TH STREET SE • CEDAR RAPIDS, IA 52401
PHONE.319.362.4433 • TOLLFREE.877.361.4433
FAX.319.362.4466

EISC Use Only!

Patient's Scheduled Date/Time

EISC Approval/Date

IF A SLEEP MEDICINE CONSULTATION IS NECESSARY, PLEASE CONTACT PCI NEUROLOGY AT **319.398.1721** DIRECTLY FOR SCHEDULING.

PATIENT PERSONAL INFORMATION

Name: ____________________

Address/City/State/Zip ____________________

Home Phone: ____________ Work Phone: ____________ Cell: ____________

Birth date: ________ Height ______ Weight ______ Gender: M F Occupation ________

Sleeping hours: From ______ To ______ ______ Night ______ Day ______ Evening

INDICATIONS & TYPE OF TESTING REQUIRED

Sleep Disordered Breathing

780.57 Sleep Apnea NOS
unless otherwise indicated at right

- ☐ 327.23 Obstructive Sleep Apnea
- ☐ 780.09 Alteration of Consciousness, Other
- ☐ 780.51 Insomnia with Sleep Apnea
- ☐ 780.53 Hypersomnia with Sleep Apnea
- ☐ 780.54 Hypersomnia NOS
- ☐ 780.55 Disruption of 24 hr Sleep Wake Cycle NOS
- ☐ 780.56 Dysfunctions associated with Sleep Stages or Arousal from Sleep
- ☐ 786.09 Snoring & other Respiratory Abnormality NOS
- ☐ 799.02 Hypoxemia

- ❑ *Diagnostic polysomnogram* with *split night* or *second night titration,* if indicated
- ❑ *Diagnostic polysomnogram only*, no additional testing
- ❑ *PAP (re)titration* with *CPAP or BiPAP* (including *autoSV or AVAPS*)
- ❑ Please *monitor PCO2* during the above testing

Previous study done at: ____________

Ref: Medicare Carriers manual; Transmittal #1725; 9/27/01

Narcolepsy & Hypersomnia

347.01 Narcolepsy with Cataplexy
unless otherwise indicated at right

- ☐ 347.00 Narcolepsy without Cataplexy
- ☐ 347.10 Narcolepsy without Cataplexy in conditions classified elsewhere
- ☐ 347.11 Narcolepsy with Cataplexy in conditions classified elsewhere
- ☐ 780.53 Hypersomnia with Sleep Apnea
- ☐ 780.54 Hypersomnia, Unspecified

- ❑ *Diagnostic polysomnogram* with *Multiple Sleep Latency Testing*

Parasomnia

Please indicate diagnosis at right

- ☐ 345.8* Epilepsy and Recurrent Seizures, with/without intractable seizures
- ☐ 780.09 Alteration of Consciousness, Other
- ☐ 780.55 Disruption of 24 hr Sleep Wake Cycle NOS
- ☐ 780.56 Dysfunctions associated with Sleep Stages or Arousal from Sleep (RBD)
- ☐ 780.58 Sleep related Movement Disorder NOS
- ☐ 780.59 Other Sleep Disturbances

- ❑ *Diagnostic polysomnogram* with *extended EEG monitoring*

Wakefulness Testing

With concerns about the patient's ability to remain awake with ongoing or past treatment

- ❑ *Maintenance of Wakefulness Test*
- ❑ *Diagnostic polysomnogram with Multiple Sleep Latency Testing*

PLEASE CONVERSE WITH A SLEEP MEDICINE PHYSICIAN IF IT IS NOT CLEAR WHICH STUDY IS MOST APPROPRIATE FOR YOUR PATIENT.

PHYSICIAN INFORMATION

Referring Physician ____________ Phone: ____________ Fax: ____________

PCP: ____________ Phone: ____________ Fax: ____________

IF YOU HAVE PROVIDED YOUR PATIENT WITH A SLEEP AID, PLEASE INSTRUCT THEM TO BRING THE FILLED PRESCRIPTION WITH THEM TO THE SLEEP CENTER. THE SLEEP TECHNICIAN WILL INFORM YOUR PATIENT WHEN THE SLEEP AID SHOULD BE TAKEN.

Referring Physician Signature: ____________ Date: ____________

Name: ______________________ Birth date: ______________

PLEASE PROVIDE PATIENT'S HISTORY, INCLUDING MEDICINES & ALLERGIES, AND PHYSICAL EXAM BELOW, OR INCLUDE A RECENT CLINICAL NOTE RELEVANT TO THIS STUDY.

HISTORY OF SLEEP PROBLEM(S) *check all that apply*

- ☐ Excessive daytime sleepiness
- ☐ Snoring
- ☐ Witnessed apneas
- ☐ Insomnia
- ☐ Frequent awakenings
- ☐ Shift work
- ☐ Morning headaches
- ☐ Nocturia
- ☐ Sleepwalking
- ☐ Cataplexy
- ☐ Sleep paralysis
- ☐ Hallucinations
- ☐ Other

MEDICAL CONDITIONS *check all that apply*

- ☐ High blood pressure
- ☐ Lung disease
- ☐ Heart disease/CHF
- ☐ Pacemaker
- ☐ Stroke
- ☐ Diabetes
- ☐ GERD
- ☐ Obesity
- ☐ Nose/Throat surgery
- ☐ Seizures
- ☐ Fibromyalgia
- ☐ Chronic Pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Cancer
- ☐ Other:

MEDICATIONS & ALLERGIES

❑ No known medical or latex allergies*		Medications & Supplements*	Dosage/Frequency	Reason for taking
Allergy	Reaction			

** Attach list or continue in comments below if more room is needed*

PHYSICAL EXAM ABNORMALITIES *check all that apply and explain below*

- ☐ Nasopharynx
- ☐ Oropharynx
- ☐ Jaw/Mouth
- ☐ Head
- ☐ Neck
- ☐ Heart/Lungs
- ☐ Neurologic
- ☐ Other:

SPECIAL NEEDS DURING TESTING *check all that apply and explain below*

- ☐ Oxygen
- ☐ Medications
- ☐ Assistance moving/Wheelchair
- ☐ Difficulty communicating
- ☐ Resident of a nursing facility
- ☐ Other:

NOTES AND COMMENTS: