Mid-Atlantic Neurology Sleep Center
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Patient Name:_____ Date of Birth:_____

Phone #'s: _____

Address: _____

Insurance: _____

Policy ID: _____ Group #_____

- **Please attach a copy of demographic sheet, insurance cards and Clinical Notes demonstrating need for sleep study**

☐ Diagnose and Treat for Sleep Disorders – Sleep Study followed by CPAP (if needed), followed by DME equipment orders (if needed)

☐ Polysomnogram (PSG)

☐ CPAP Titration (CPAP)

☐ BiPAP Titration (BiPAP)

☐ Multiple Sleep Latency Test (MSLT)

☐ Home Sleep Study (HST)

☐ Sleep Consultation with Sleep Specialist

☐ Other_____

Symptoms

☐ Witnessed Apnea
☐ Loud Snoring
☐ Morning Headaches
☐ Excessive Daytime Fatigue
☐ CHF / Pulmonary HTN
☐ Nocturnal Seizures
☐ Hypertension
☐ Insomnia
☐ Obesity
☐ Restless Sleep
☐ Mood changes
☐ Afib/Arrythmia
☐ Other: _____

Suspected Diagnosis

☐ Obstructive Sleep Apnea
☐ Restless Sleep (PLMD/RLS)
☐ Other: _____
☐ Narcolepsy
☐ Parasomnia
☐ Insomnia

Physician Name: _____ NPI #:_____

Physician Address: _____

_____

Physician Phone: _____ Fax#:_____

Physician Statement:
I have carefully reviewed this form and find this test to be medically necessary.

Physician Signature: _____ Date:_____