



Sleep Disorders Laboratory
Appointments 510-428-3809
Fax 510-450-5857

Sleep Clinic - Oakland
Appointments 510-428-3209
Fax 510-597-7154

Sleep Clinic - Walnut Creek
Appointments 925-979-4000
Fax 925 939-8987

Karen A. Hardy, MD- Division Director
Haramandeep Singh MD, D. ABPN -Medical Director
Katie Sabato, MS, RRT- Director

REQUEST FOR POLYSOMNOGRAPHY (SLEEP STUDY)

DATE OF REQUEST: _____

I. PLEASE OBTAIN AUTHORIZATION FOR CPT CODES #1 , #2 AND #3 for CCS Approval:

1. Sleep Clinic Consultation – 99245 2. Standard overnight sleep study – 95811 3. Sleep Study CCS Code Z7602

OTHER TESTS OFFERED

3. Sleep study with CPAP/BiPAP 95811 4. Ventilatory and arousal testing (gas challenges) – 94400; 94450
5. Multiple sleep latency test (MSLT) 95805 6. Maintenance of wakefulness test

II. ORDERING PHYSICIAN:

Name: _____

Address: _____ City: _____ CA ZIP: _____

Phone: _____ Fax: _____ Contact Person: _____

How urgent do you consider this study?

Urgent 1-2 wks 1 mo Routine

I am the patient's: [] Pediatrician [] Resident/Physician [] Hematologist/Oncologist** ** Send Requests directly to Sleep Lab
[] Pulmonologist** [] Otolaryngologist/ENT** [] Craniofacial Subspecialty Provider **

Interpreter needed? NO YES – Language: _____

Primary Care Physician: _____ Phone: _____

III. PATIENT DEMOGRAPHICS

Name: _____ Birthdate: _____ Med.Rec.#: _____ [for office use only]

Address: _____ City: _____ CA. Zip: _____

Parents Name: _____ Would you like to be placed on our Call List for cancelled appointments? YES NO

Home phone: _____ Work phone: _____ Cell phone: _____

IV. PATIENT CLINICAL DATA – (send your clinic visit note)

Diagnoses AND ICD-9 code:

Relevant symptoms (i.e. sleep history, snoring, awake behavior or findings, physical signs, etc.)

Snoring? Obesity? Recent Wt: Tonsils? (1 – 4+)

Medications and reason for:

Any respiratory support? (e.g. ventilator, CPAP/BIPAP, etc.)

Special instructions, comments? (physical info, limitations, special considerations, psychological info, etc.)

V. INSURANCE INFO

Primary Insurance plan name: _____ Type of plan: HMO PPO state federal

Subscriber name: _____ Relationship _____

Policy or ID#: _____ Claims address: _____

Group #: _____

Phone: _____

Insurance authorization number: _____ Expiration date: _____

The sleep clinic consultation and/or study is a covered benefit; therefore NO AUTHORIZATION is REQUIRED (NAR): _____ Contact Person initial

For Sleep Studies, we will contact the family to schedule an appointment once the form is returned to us. Fax: 510-450-5857 Sleep Lab.
Please do not fax back until ALL the information we have requested is submitted. Thank you for your referral!