UCSF Benioff Children's Hospitals
Walnut Creek Campus

Sleep Disorders Laboratory
POLYSOMNOGRAPHY (SLEEP STUDY) ORDER FORM

Appointments: 925-979-3429 | Fax: 510-985-2202

Please complete all form fields to help us decide the best set-up for the study and assist with scheduling. We encourage you to contact us to discuss your patient.

DATE _____ TIME of REQUEST:_____PRINT PHYSICIAN'S NAME: _____

I. PLEASE OBTAIN AUTHORIZATION FOR CPT CODES:

1. Sleep Study >6 yrs - 95810, 94770
2. Sleep Study <6 yrs - 95782, 94770
3. Sleep Study >6 yrs w/ CPAP/BiPAP - 95811, 94770
4. Sleep Study <6 yrs w/ CPAP/BiPAP - 95783, 94770
5. Pharyngeal pH probe - 91034
6. Capped sleep study (for tracheostomy)

II. ORDERING PHYSICIAN SIGNATURE:

Name:

Address: City: CA ZIP:

Phone: Fax: Contact Person:

How urgent do you consider this study? ☐ Emergent (< 1 week) ☐ Urgent (1-2 weeks) ☐ Routine

Interpreter needed? ☐ NO ☐ YES - Language: _____

Primary Care Physician: Phone:

III. PATIENT DEMOGRAPHICS:

Name: _____ Birthdate: _____ ☐M / F☐Med. Rec. #: _____

Address: _____ City: _____ CA, ZIP: _____

Parent's Name: _____ Would you like to be placed on our Call List for cancelled appointments? ☐YES ☐NO

Cell Phone: _____ Home Phone: Work Phone:

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

Diagnoses and ICD-10 code:

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

Snoring? % BMI? Recent Wt.: Tonsils? (1-4+)

Medications and reason(s) for:

Any respiratory support? (oxygen, CPAP / BiPAP, tracheostomy, etc.)

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

V. INSURANCE INFO (Provide Copy of Insurance Card):

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

Fax form to: 510-985-2202

We will call the family to schedule an appointment once the completed form is returned to us.
Please don't fax this form back until ALL information requested is filled out. Thank you for your referral!

Patients who have not been seen by a sleep specialist, pulmonologist or otolaryngologist will need a sleep consultation prior to the Sleep Study.

Contact us to schedule a Sleep Consultation for Oakland or Walnut Creek: Appointments:510-428-3305