

# Grand Forks Center for Sleep

3301 30<sup>th</sup> Ave S  
Grand Forks, ND 58201  
701-757-4800 phone  
701-757-4804 fax

PATIENT NAME	Last Name	First Name	Initial
DOB:	ADDRESS	CITY	STATE
		ZIP	
PHONE	ALTERNATE PHONE		

## MEDICAL JUSTIFICATION FOR POLYSOMNOGRAPHY (Sleep Study) - Please check one or all that apply:

- EDS - Excessive daytime sleepiness (hyper somnolence) that significantly interferes with the patient's well-being, health, and functional status.
- Observation of witnessed apneas (The patient may be unaware of this symptom – usually the bed partner is extremely aware of this).
- Snoring – must be associated with some impairment or sleepiness during the day.
- Unexplained, life threatening cor pulmonale (especially when associated with snoring and EDS).

\*This information is required to allow the Business Office to obtain prior authorization for the procedure to insure insurance coverage. Once authorization is obtained, appointments will be arranged with the patient. Prior authorization is not a guarantee of benefits.

Has patient had previous sleep study? \_\_\_YES \_\_\_NO If yes, when and where? \_\_\_\_\_  
If previous sleep study, please provide testing results.

Is patient on oxygen during the day? \_\_\_\_\_ Is patient on oxygen during the night? \_\_\_\_\_

Special indications indicate here (Wheelchair bound, Insulin dependent etc,) \_\_\_\_\_

## STUDY TYPE:

- PSG/Split-night – Minimum of 2 hours diagnostic followed by initiation and titration of CPAP/BiPAP therapy when indicated per protocol. **Recommended for 1<sup>st</sup> Study or reassessment of patients on therapy for several years.**
- CPAP titration – CPAP to be initiated at the start of the study and titrated per protocol. **Recommended for 2<sup>nd</sup>/repeat study --Insurance may require split night depending upon date of previous study or patient change in insurance carrier.**

**It is highly recommended that you prescribe a sleep aid for your patient to bring with the night of their sleep study. The patient should not take this medication until they arrive to the lab and are instructed by the sleep technician. Recommendation would be 5mg X 2 of Ambien.**

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Name (Please print) \_\_\_\_\_

NPI Number \_\_\_\_\_

Physician Phone # \_\_\_\_\_ Physician Fax # \_\_\_\_\_

Physician signature indicates an order for a fully attended polysomnogram with CPAP titration (if indicated). Complete this form and **FAX to 701-757-4804.**