Lowell General Hospital - Sleep Lab and Neurodiagnostics Center

Office (978) 937-6090 Fax (978) 937-6807

Name:	Date:
SS #:	DOB:
Address:	Address:
Home Phone:	City/State/Zip:
Cell Phone:	PCP:
1st Ins:	1st Ins. ID #:
2nd Ins:	2nd Ins ID #:
Policy Holder:	
Emergency Contact:	Emergency #:
Translator Needed: ☐ Yes ☐ No	Language:

****FreeCare patients must have a letter of Medical Necessity prior to scheduling Test****

Ordering Physician (Please Print): _____

Physicians Signature _____

(Orders accepted from MD, RNP, or PA only. All others must be co-signed by a physician)

☐ ***A recent H&P is attached and/or will be forwarded prior to study***

Does Patient have special needs? i.e. wheelchair or on O2 _____

**Pts from extended care, group homes or Psych facilities require an attendant or family member to accompany them for the night. **

✓	SIGNS & SYMPTOMS	✓	SIGNS & SYMPTOMS
	Excessive Daytime Sleepiness (780.54) Hypersomnia, Unspecified		Obstructive Sleep Apnea (780.53) ***C-PAP Titration***
	Insomnia, Unspecified (780.52)		
	Sleep Related Movement Disorder, Unspecified (780.58)		Narcolepsy, NOS (347.00) ***Multiple Sleep Latency Testing (MSLT)***
	Sleep Apnea, Unspecified (Primary Snoring) (780.57)		
	Other:		

TEST ORDERED

☐ Polysomnogram (All night diagnostic study)

☐ Split night (PSG + CPAP if estimated RDI >20 and/or desats below 80% within 1st 2-3 hours of testing.)

☐ CPAP/BiPAP Titration/ ReTitration (All night, must have previous PSG or presently on CPAP/BiPAP) Previous Sleep Study Date: _____ Location _____

☐ MSLT (Patient should have signs/symptoms of Narcolepsy and/or have a negative PSG with no evidence of sleep disordered breathing.)

☐ Please place patient on the cancellation list

Scheduled Date: _____Time: _____