Wise Health System

Affiliated with, but not controlled by, Baylor Scott & White Health or its subsidiaries or community medical centers

Sleep Wellness Center

Please attach a copy of the patients: Insurance card Demographics Current H&P

Sleep Order Form

2000 S FM 51. Decatur, Texas 76234
Phone: 940-626-8818
Fax: 940-626-8819

Patient Name ***(Required)*** **Sex** **Date of Birth** ***(Required)*** **Social Security #**

Cell Phone ***(At least one is required)*** **Work Phone** **Home Phone**

Address **City** **State** **ZIP Code**

Assessment/Indications

Clinical Indication for Referral:

☐Organic Sleep Apnea, Unspecified G47.33
☐Obesity Hypoventilation Syndrome G47.36
☐OSA (Adult) (Pediatric) G47.33
☐Drug Induced Sleep Disorders F10.982
☐ Other Organic Sleep Related Movement Disorders G47.53
☐ Periodic Limb Movement Disorder G47.61
☐ Narcolepsy Unspecified G47.411/G47.4119
☐ Other: _____

Associated Symptoms:

☐ Loud Snoring
☐ Seizures, Sleep Twitching or Jerking
☐ Excessive Daytime Sleepiness – G47.10
☐ Congestive Heart Failure, Unspecified
☐ Coronary Artery Disease, CAD
☐ Chronic Obstructive Pulmonary Disease, COPD
☐ Chronic Pain/Narcotic Use
☐ Daytime Somnolence affecting Vocation
☐ Obesity with inability to lay flat/Morbid
☐ Hypertension, HTN
☐ TIA/Stroke
☐ Other: _____

Epworth Score: _____
A score >10 indicates moderate to severe indication

STOP Bang: _____
Yes to >2 indicates high probability

Berlin: _____
A positive score in >1 category indicates moderate to high probability

Orders

Sleep Services Ordered:

☐ Diagnostic Sleep Study ONLY - 95810
☐ SPLIT night Sleep Study – 95811
☐ CPAP Titration – 95811; **2ND NIGHT TITRATION ONLY**
☐ BIPAP Titration– 95811; **FAILED CPAP, ADV. TITRATION**
☐ASV study after recent diagnostic – 95811
☐ MWT – 95805
☐ PAP Re-Titration– 95811;**2ND NIGHT TITRATION ONLY**
☐ HST – Home sleep study- 95806
☐MSLT– 95805; **Preceded by PSG sleep study**

**** It is very important for the safety and comfort of the patient we know of any special needs they may have. Please have patient bring their medications and indicate whether patient has:***

☐ Oxygen ☐Care Giver/Aide Required ☐Wheelchair ☐Walker/Mobility Issues ☐Shift Worker

Other Special Instructions/requests: _____

Physician's Name **Phone/ Fax Number**

Physician's Signature ***(Required)*** **Date/ Time** ***(Required)***