



# 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; **2<sup>ND</sup> NIGHT TITRATION ONLY**
- BIPAP Titration– 95811; **FAILED CPAP, ADV. TITRATION**
- ASV study after recent diagnostic – 95811

- MWT – 95805
- PAP Re-Titration– 95811; **2<sup>ND</sup> 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)

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