SLEEP DISORDER CENTER

Phone | 805.667-8049 Fax | 805.487-3100

Rx & Certificate of Medical Necessity

►PATIENT INFORMATION

Name: _____ **D.O.B:** _____ □ **MALE** □ **FEMALE**

Address: _____ **Phone:** _____

Insurance Carrier: _____ **ID#:** _____

►CARDIO SLEEP TEST (CARDIAC & SLEEP)

Select at least one DX for Cardio and Sleep for combo testing

CARDIO DX: □ Palpitations R00.2 □ Cardiac Arrhythmia I49.9 □ Abnormal EKG □ Other_____

SLEEP DX: □ Obstructive Sleep Apnea G47.33 □ Sleep Apnea G47.30 □ Sleep Disorder G47.9

□ **Cardio and Sleep Test** *Diagnostic Sleep Test & 1-day Holter & 7-day Mobile Cardiac Telemetry if Holter was un-revealing*

►SLEEP TESTING ONLY

SLEEP DX: □ Obstructive Sleep Apnea G47.33 □ Sleep Apnea G47.30 □ Sleep Disorder G47.9

□ **Diagnostic Home Sleep Test**

□ **Efficiency Home Sleep Test** (w/Oral Appliance)

□ **Efficiency Home Sleep Test** (w/PAP machine)

►CARDIAC TESTING ONLY

CARDIO DX: □ Palpitations R00.2 □ Cardiac Arrhythmia I49.9 □ Abnormal EKG □ Other_____

□ **Mobile Cardiac Telemetry** □ 3 days □ 7 days □ 14 days □ Other _____

►CONSULTATION

□ **Comprehensive Consultation** (Sleep and Cardio)

►SYMPTOMS

□ Snoring	□ Witnessed Apnea	□ Shortness of Breath	□ Dizziness or Lightheadedness
□ Hypersomnia	□ Unrefreshed Sleep	□ Chest Pain or pressure	□ Excessive Daytime Sleepiness
□ Insomnia	□ Headaches	□ Dry mouth/throat	□ Fainting/Near-fainting Spells

►MEDICAL HISTORY

□ Hypertension	□ Obesity	□ Diabetes, Type II	□ Heart Disease
□ Depression	□ Asthma	□ Stroke	□ Atrial Fibrillation
□ Anxiety	□ Sleep Apnea	□ Heart Attack	□ Coronary Artery Disease

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►PROVIDER INFORMATION

Name: _____ **Provider Address:** _____

NPI #: _____ _____

Phone: _____ **Fax:** _____

Provider Signature: _____ **Date:** _____/_____/_____