Comprehensive Sleep Medicine Associates
CSMA
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JERALD H. SIMMONS, MD

Medical Requisition Form

REQUESTS FOR CLINICAL EVALUATION

☐ **Consultation with follow up with a Sleep Medicine Specialist**

☐ **Consultation without follow up with a Sleep Medicine Specialist**
(Even if the patient will not follow with the specialist after testing, consultation prior to testing is recommended to allow the specialist to determine the proper form of testing and facilitate obtaining prior authorization for testing)

☐ **Consultation and follow up with a Neurologist for non-sleep issues such as headaches or patients with "spells" (spells range from *seizures, lapses of awareness, changes in behavior, or headaches*).**
Please include a brief history with patient's symptoms.

DIAGNOSTIC EEG TESTING WITHOUT EVALUATION*

☐ **Routine EEG**

☐ **Ambulatory Video EEG**

DIAGNOSTIC SLEEP TESTING WITHOUT EVALUATION*

☐ **Home Sleep Apnea Test (HSAT)**

☐ **Diagnostic Nocturnal Polysomnogram (NPSG) ("In-lab Sleep Study") – performed to evaluate for sleep-related abnormalities (e.g.; OSA; sleep-related movement disorders like RLS, teeth clenching/grinding, parasomnias)**

☐ **With PES – measures pressure within the esophagus to measure respiratory effort more accurately**

☐ **With Video EEG – 16 EEG leads are applied in addition to standard EEG measurement for NPSG to determine if spells during sleep have epileptiform characteristics**

☐ **CPAP/Bi-Level PAP Titration NPSG – performed to determine the optimal PAP pressure setting to treat sleep apnea**

☐ **With PES – same as with NPSG above, but performed during PAP titration**

☐ **With Video EEG – 16 EEG leads are applied in addition to standard EEG measurement for NPSG to determine if spells during sleep have epileptiform characteristics**

☐ **Multiple Sleep Latency Test (MSLT) – performed to assess for conditions of hypersomnolence (e.g., narcolepsy)**

☐ **Maintenance of Wakefulness Test (MWT) – performed to assess the patient's ability to stay awake**

*** Note: If testing is ordered without consultation, the provider ordering the test will be required to obtain prior authorization, if required by the patient's insurance. Our office will obtain prior authorization if a CSMA provider provides consultation prior to testing.**

Diagnosis: _____

Brief History: _____

_____

_____

_____

_____

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_____

PLEASE PRINT:

Patient's Name (Last, First)
_____

Date of Birth (m/d/y) :____
/____/_____

Phone Numbers THREE if possible:
_____

Insurance: Name:_____
Policy#_____ **Grp#** _____

Date of request(m/d/y):____/_____/_____

Requesting Clinician: _____

Doctor's Office # _____

Doctor's Fax # _____