

LOMA LINDA UNIVERSITY MEDICAL CENTER SLEEP DISORDERS CENTER

11360 Mountain View Avenue

Hartford Building, Suite D

Loma Linda, CA 92354

Phone: (909) 558-9999 Fax: (909) 558-6343

Accredited by the American Academy of Sleep Medicine Since 1991

ORDER FORM

Patient Demographics (Required)

Patient Name: _____ Male Female DOB: ____/____/____

Phone (h): _____ Phone (c): _____

Patient History (Required)

Recent progress note attached * No Yes *A recent progress note **MUST** be attached to proceed with scheduling your patient for a polysomnogram.

Prior Polysomnogram * * LLU * Other facility: _____ year _____

Reason for Polysomnogram (Required)

Sleep Apnea Parasomnia Narcolepsy

Testing Ordered: Check all that apply (Required)

-ADULT-

- Standard (Split-Night) PSG (95810)/ (95811) *Positive airway pressure (PAP) therapy will be initiated per PAP protocol*
- PAP Titration PSG (95811)
- Multiple Sleep Latency Test (95805) *PSG required the night before, per protocol*
- Maintenance of Wakefulness Test (95805)
- Portable Unattended Home Sleep Study (95806)
- Special Instructions: _____

-PEDIATRIC-

- Baseline PSG (95810) *Does **not** include PAP therapy*
- PAP Titration PSG (95811)
- Baseline PSG < 6 years of age (95782)
- PAP Titration < 6 years of age (95783)
- Special Instructions: _____

Physician Information (All Fields Required)

Ordering Physician: _____ Physician Phone: _____ Physician Fax: _____

Ordering Physician Signature: _____ Date: ____/____/____

A COMPLETED ORDER FORM AND PAYOR AUTHORIZATION (IF APPLICABLE) IS REQUIRED BEFORE A STUDY CAN BE SCHEDULED.

PLEASE FAX COMPLETED ORDER FORM AND AUTHORIZATION TO (909) 558-6343