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)

	No	Yes	
Recent progress note attached	☐*	☐	*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 ☐ Other: _____

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 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