Clinical Summary—AUTH Application

Patient Name:_____ **DOB**:_____ **Appt date**:_____

Patient height:_____ Patient weight:_____

Ref. Physician: _____ Dr.'s Billing Address_____ Dr.'s Phone:_____
Dr.'s Fax:_____ Dr.'s NPI#:_____ Dr.'s Tax ID#:_____

Facility Name:_____ Phone:_____ Fax:_____
Facility Address:_____ NPI#:_____ Tax ID#:_____

Insurance Co:_____ Member#:_____ Group#:_____
AUTH#:_____ Tracking#/Call Ref#/Name:_____
Effective:_____ to _____ Per:_____ Ph#:_____ Fax#:_____

Suspected Diagnosis: (Check ALL boxes that apply to the patient's diagnosis):

□ G47.33 Obstructive sleep apnea (adult) (pediatric)
□ G47.30 Sleep apnea, unspecified
□ G47.31 Primary central sleep apnea
□ G47.39 Other sleep apnea
□ G47.37 Central sleep apnea in conditions classified elsewhere
□ Other: _____

Type of Study Requested (PLEASE CHECK ONE BOX):

□ Diagnostic PSG (CPT 95810)
□ CPAP/BiLevel Titration (CPT 95811)
□ Split Night Study (CPT 95811)
□ Home Sleep Study (HST) (CPT 95806)
□ Multiple Sleep Latency Test (MSLT) (CPT 95805) (PSG performed previous night)
□ Maintenance of Wakefulness Test (MWT) (CPT 95805)

□ Sleep Concerns?: (check below for all that apply)

□ Snoring
□ Witnessed Apneas
□ Back pain / sleeps in recliner
□ ≥ 3 "Yes" on STOP Bang Questionnaire
□ Difficulty Initiating / maintaining sleep
□ Gasping / choking / SOB
□ Upper airway abnormality: class__Mallampati
□ Enlarged tongue
□ Nocturia
□ Parasomnia:_____
□ Periodic Limb Movements
□ Fibromyalgia
□ Bruxism
□ Other _____

□ Daytime Concerns?: (check below for all that apply)

□ Awakens w dry mouth / sore throat / headache
□ Impaired mood
□ Awakens groggy / unrefreshed
□ Sleepiness-related auto crash
□ Impaired daytime activities
□ Dementia / brain injury
□ Pt. unable to operate HSAT Device
□ Sleeping at inappropriate times
□ Daytime Sleepiness
□ Other _____

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□ Comorbidities?: (check below for all that apply)

□ Recent history of Pressure Ulcers
□ Heart Attack
□ Moderate to severe pulmonary disease (with pO2 less than 60 or pCO2 greater than 45)
□ Neuromuscular disease
□ Stroke
□ Epilepsy
□ Congestive heart failure or other CVD
□ Super obesity (BMI greater than 45)
□ Periodic limb movement disorder
□ Parasomnias
□ Narcolepsy
□ Pt. on supplemental O2 _____LPM
□ Obesity Hypoventilation Syndrome
□ Central sleep apnea or complex sleep apnea
□ Hypertension
□ Diabetes
□ Atrial Fibrillation or other significant Cardiac Arrhythmia
□ Other __

□ Previous Sleep Study Test Results?: (check below for all that apply)

□ Unknown / Lost / Report not available
□ Sleep Study CPT#_____ Done on: _____/_____/_____;
AHI:_____/hr; Diagnosis:_____;
(PLM+Arousal Index) Periodic Limb Movements + Arousal Index:_____/hr;
REM O2 Nadir:_____%; NREM Nadir:_____%; O2 Sat < 88% for _____% of TST;
Central / Mixed apneas were / were not present during sleep period;
Other: _____

□ Change in Medical Condition Since Previous Study?: (check below for all that apply)

□ Weight gain / loss _____lbs
□ Increase in Daytime Sleepiness
□ Failure to resolve OSA Symptoms
□ Recurrence of OSA Symptoms
□ New medical conditions related to sleep:_____