A PARTNERSHIP
UNITYPOINT-ST. LUKE'S HOSPITAL • MERCY MEDICAL CENTER • PHYSICIANS' CLINIC OF IOWA
EASTERN IOWA SLEEP CENTER
275 10TH STREET, SE, SUITE 3330 • CEDAR RAPIDS, IA 52403
PHONE.319.362.4433 • TOLLFREE.877.361.4433
FAX.319.362.4466
UnityPoint Health
Finley Hospital

EISC Use Only – Thank you!

Scheduled Date/Time:

EISC Dr. signature:

EISC Approval/Date:

EISC No:

PATIENT PERSONAL INFORMATION

First name: _____ Last name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell phone: _____ Home phone: _____ Work phone: _____

DOB: _____ Gender: M F Weight _____ Height _____ Neck circumference _____ inches

Special needs: ☐ Oxygen ☐ Wheelchair ☐ Walker ☐ Other _____

INSURANCE INFORMATION: Please provide front and back for card(s)

Primary Insurance: _____ Secondary Insurance: _____ Pre- Auth Form/ #: _____

SUBMIT ORDER WITH H & P – Insurance requires medical necessity be established by a face-to-face visit by the ordering provider prior to the study and documented in the patient's H & P. Medical necessity includes, but not limited to two sleep symptoms: snoring, witnessed apnea, choking or gasping during sleep, morning headaches, excessive daytime sleepiness, disturbed/ restless sleep. Additional comorbidities and symptoms may be sent as appropriate.

PROVIDER ORDERS:

DX: G47.33 OSA (unless otherwise indicated) DX: _____ DX: _____

❏ Diagnostic PSG 95810 & 95811 (polysomnogram) w/ split night if indicated
❏ Diagnostic PSG 95810 (polysomnogram) **ONLY**, no additional testing
❏ PAP (re)titration with CPAP or BiPAP (including autoSV and AVAPS)
❏ Home sleep test 95806 (High pre-test OSA **ONLY**)

For MWT, MSLT, Actigraphy and/or specialized sleep issues please see Sleep Medicine Provider first.

Previous study done at:

Sleep Aid: None: ____ Zaleplon(Sonata) _____ mg Zolpidem(Ambien) _____ mg Eszopiclone(Lunesta)_____mg Other:_____

IF YOU HAVE PROVIDED YOUR PATIENT WITH A SLEEP AID, PLEASE INSTRUCT THEM TO BRING THE FILLED PRESCRIPTION WITH THEM TO THE SLEEP STUDY. THE SLEEP TECHNICIAN WILL INFORM YOUR PATIENT WHEN THE SLEEP AID SHOULD BE TAKEN.

NOTES & COMMENTS

Referring Provider (Print) _____ Phone: _____ Fax: _____

Referring Provider Signature: _____ Date: _____

PCP (if different): _____ Phone: _____