



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  
RESPIRATORY CARE/LAB FAX.563.927.7513

**RMC**

Regional Medical Center®

*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

Sleep hours:  Night  Day  Shift work  Other hours \_\_\_\_\_

Special needs:  Oxygen  Wheelchair  Walker  Other \_\_\_\_\_

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

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_ Pre- Auth Form/ #: \_\_\_\_\_

### ATTACH ORDERING PROVIDER NOTES - Per insurance requirements medical necessity must be established prior to the study and documented in the patient medical record.

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. Any added information such as: co-morbid conditions, validated Epworth Sleepiness Scale, duration of sleep symptoms, BMI, neck circumference, focused cardiopulmonary and upper airway system evaluation and other factors as appropriate.

### PROVIDER ORDERS:

DX: 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: \_\_\_\_\_