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

EISC Use Only – Thank you!

Scheduled Date/Time:

EISC Dr. signature:

EISC Approval/Date: CO2: Y N

EISC No:

Patient first name: _____ Patient 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 by a face-to-face visit by the ordering provider prior to the study and documented in the patient medical record.**

Medical necessity includes, but not limited to 2 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: OSA (unless otherwise indicated) DX: _____ DX: _____

- ❑ Diagnostic PSG 95810 & 95811 (polysomnogram) w/ split night if indicated
- ❑ Diagnostic PSG 95810 (polysomnogram) **ONLY**, no additional testing
- ❑ Home Sleep Apnea Test 95800 or 95806 (HSAT) High pre-test OSA **ONLY**
- ❑ PAP (re)titrations with CPAP or BiPAP
- ❑ Consider CO2 monitoring

Previous study done at:

Failed CPAP & BiPAP – a Sleep Medicine consult is required for next steps, including potentially BIPAP-ASV, BIPAP-ST or other treatment options.

For MWT, MSLT, Actigraphy please discuss with a Sleep Medicine Provider first.

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.

Select one of the following should the patient have a sleep disorder:

☐ Send the patient for follow up and treatment to a PCI Sleep Medicine Provider.

☐ I will follow up with the patient regarding the test results.

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

Referring Provider Signature: _____ Date: _____

PCP (if different): _____ Phone: _____