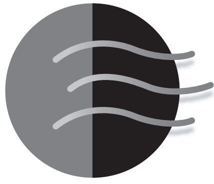

A PARTNERSHIP
UNITYPOINT-ST. LUKE'S HOSPITAL • MERCY MEDICAL CENTER • PHYSICIANS' CLINIC OF IOWA

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:

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 apnea test 95800 (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: ______________