LAKE CITY CLINIC
301 NW COLE TERRACE STE 103
LAKE CITY, FL 32055

SLEEP SOLUTIONS OF NORTH FLORIDA, LLC

Atlas Sleep HOME SLEEP TESTING
A division of Sleep Solutions of North Florida (IDTF)

GAINESVILLE CLINIC
6604 NW 9TH BLVD
GAINESVILLE, FL 32605

PHONE: (386) 752-6700 | FLORIDA LOCAL FAX (386)752-6709 | **FAX (888)-428-0533**

SLEEP STUDY ORDER FORM

PATIENT INFORMATION

Last Name:	First Name:
Date of Birth: (mm/dd/yyyy)	Gender: ☐ Male ☐ Female ☐ Other
Primary Phone:	Alternate Phone:

PRIMARY INSURANCE

** Please attach a copy of patient's insurance card (front & back)*

☐ Insurance Plan	Subscriber ID#:
☐ Self-Pay/No Insurance	

SECONDARY INSURANCE

Insurance Plan:	Subscriber ID#:

COMORBID CONDITIONS

☐ Obesity Hypoventilation	☐ Congestive Heart Failure	☐ History of Stroke	☐ Severe OSA
☐ Neuromuscular/ Degenerative	☐ Hypertension (Pulmonary)	☐ COPD	☐ Asthma

PROCEDURE

☐ Polysomnography Test-PSG (Sleep Study) w/Split Night Study or Separate CPAP Titration (in patient qualifies)

☐ CPAP/BiPAP Titration

☐ Multiple Sleep Latency Test-MSLT (Daytime Nap Study)

☐ Other Type Study:

☐ Home Sleep Test-Unattended: *Home sleep study if insurance allows, if not then inlab where available. "On Room Air" unless the following is checked:*

Is patient currently on Oxygen/o2? ☐ YES ☐ NO If Yes, List Level:	If patient is currently on Oxygen, would you like for their study to be started with Oxygen/o2? ☐ YES ☐ NO

PRELIMINARY DIAGNOSIS/ DIAGNOSIS

☐ G47.00–Organic Insomnia (Unspecified)	☐ G47.33–Obstructive Sleep Apnea (OSA)	☐ G47.41–Narcolepsy
☐ G47.13–Recurrent Hypersomnia	☐ G47.61–Periodic Limb Movement Disorder	
☐ G47.31– Primary Central Sleep Apnea	☐ Other ICD_10 _ _ _ - _ _ - _____	

PROVIDERS SPECIAL REQUEST

**By completing the section below; the provider allows Sleep Solutions | Atlas Sleep to also release the patients test results to the specified DME company or Board Certified Sleep Specialist, for the purpose of the patient's treatment of therapy.*

☐ Refer patient only back to Referring Provider

☐ Allow Sleep Solutions | Atlas Sleep to select DME Company for patient's CPAP Therapy Equipment

☐ Refer patient to (DME Company) = _____ for patient's CPAP Therapy Equipment

☐ Refer patient to a Board Certified Sleep Specialist to follow patient's Treatment and Therapy

☐ Refer to Board Certified Sleep Specialist for Telehealth Medicine

ORDERING PROVIDER

***Provider Signature & Certification:** Stamped dates/signatures are not valid. Physicians/PA/NP only./ the undersigning certify that by signing below that I am ordering a Sleep Test for the patient listed above. I certify that this order is not for screening purposes for an asymptomatic patient. I also understand Medicare coverage guidelines require face to face clinical evaluation for signs/symptoms of Obstructive Sleep Apnea to be documented in the patient's medical record prior to a home sleep test.*

Provider Name:	NPI#:
Office Name:	Office Phone:

Provider Signature: X _____ **Date:** ___/____/_____

** Attach Patient's Supportive *Clinical Notes*, Current *Demographics/Insurance*. For *Insurance Pre-Authorization***