AASM Accredited Sleep Center

BON SECOURS
SLEEP DISORDER INSTITUTE
AT GOOD SAMARITAN HOSPITAL
Bon Secours Charity Health System

SLEEP STUDY INSTRUCTIONS

Thank you for referring your patient to the Bon Secours Sleep Disorder Institute. The Sleep Institute is conveniently located on the 2nd floor and is fully equipped to provide the highest quality diagnostic service to physicians in this area. In order to facilitate proper scheduling and testing, please follow the instructions below for completing the following enclosed forms: History & Physical form, Insurance Study & Request form and the Epworth Sleepiness Scale. For your convenience, **please make copies for future use**.

Please be advised that the test requested will need approval from the Sleep Disorder Institute director to ensure that the appropriate test is being ordered.

History & Physical form (Note: The signature of requesting doctor and date must be on the History and Physical form. Also, please be sure to include the patient's allergies).

A. Option #1 - You may choose to dictate the H&P via Good Samaritan Hospital dictation system (368-5291) and C.C. a copy to the sleep center. (For those with dictation access)
B. Option #2 - Please fill-out enclosed form with a signature (NOT STAMPED) at the end of the form.
C. Option #3 - An office H&P with appropriate working diagnosis and test requested related to the sleep test ordered. Please indicate follow-up information and referring physicians' information so a copy of the test will be forwarded to the appropriate office(s).

Insurance & Study Request form

A. Complete the patient information.
B. A copy of the patient's insurance card (front & back).
C. Pre-certification portion filled out and authorization approval obtained with patient's insurance company. For pre-certification, use procedure code: (95810/PSG), (95811/CPAP/SPLIT), (95805/MSLT) DX-780.53 "R/O OSA". Also, make sure that Good Samaritan Hospital is participating with patient's insurance. GSH tax ID#: 131740104. **Note: Pre-certification must be valid at the time of the sleep study.**
D. Your patient will be called by sleep institute staff to setup the study date and pre-testing instructions will be mailed to your patient. Please fax all relevant information to sleep center at 845 368-5516. **Note: The signature of requesting doctor must be on Insurance & Study Request form (NOT STAMPED) as required by the hospital for requisition of the insurance auditors.**

If your patient requires special assistance (ie. wheel chair, special aid, etc.), please notify the sleep institute in advance.

If patient is on oxygen regularly, please indicate if the study is to be done with or without oxygen.

If you have any questions regarding our services, our direct line is 845 368-5512. We hope to hear from you soon.

Sincerely,
The Staff at the Bon Secours Sleep Disorder Institute

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Insurance & Study Request Form

Patient Name: First: _____MI:_____Last: _____Sex: _____Male_____Female

Address: _____City: _____State_____ Zip: _____

Phone: (H) _____(W) _____Date of Birth: ____/____/____SS#: _____

Requesting MD:_____Primary Care MD: _____

Phone: _____Fax: _____

Please submit a photocopy of the patient's insurance card (FRONT & BACK)

Requesting MD contact person:_____ Insurance ID#: _____

Primary Ins. Carrier _____Secondary Ins. Carrier_____

Insurance contact person: _____ Phone #: _____

Pre-Certification #: _____ Date of Precertification: ____/____/____

Test Requested:

__Polysomnography (PSG)
__Polysomnography (PSG) with Seizure Montage
__ Polysomnography (PSG) with Multiple Sleep Latency Test (MSLT)

__Split-Night Study
__CPAP Titration
__CPAP Re-titration

PHYSICIAN SIGNATURE: _____ Date: ____/____/____

Office Use Only

Test Scheduled:

__Polysomnography (PSG)
__ Polysomnography (PSG) with Seizure Montage
__Polysomnography (PSG) with Multiple Sleep Latency Test (MSLT)

__Split-Night Study
__CPAP Titration
__CPAP Re-titration

Date of study: _____

Assigned Medical Record #: _____ Approved by:___

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History & Physical Form

Patient Name: First: _____MI:_____ Last: _____

CC:

___Snoring	____Wks	____Mo	____Yrs
___Witnessed apnea	____Wks	____Mo	____Yrs
___Excessive daytime sleepiness	____Wks	____Mo	____Yrs
___Difficulty initiating/maintaining sleep	____Wks	____Mo	____Yrs
___Abnormal movements during sleep	____Wks	____Mo	____Yrs

Post procedure: ____PSG/CPAP ____surgery ____oral appliance

Other: _____

PMH:

____CAD	____HTN	____CHF	____Arrhythmia
____Asthma	____COPD	____Rhinitis	____ Home O_2 –Specify ____
____Seizure	____Restless leg		
____Fibromyalgia	____Chronic Pain Syndrome	Other: _____	
____Insomnia			

PSH: ____Tonsillectomy ____Rhinolplasty ____ UPPP ____ Mandibular/Maxilofacial Other: _____

Psychiatric History:

____Depression ____Dysthymia ____Bipolar

MED:

ALLERGY:

Epworth Sleepiness Scale: (SEE ATTACHED FORM)

PE: **P:** **R:** **BP:** **Ht.:**

Wt.:

HEENT
CV
CHEST
ABD
EXT
NEURO

Working Diagnosis:

____Primary Snoring	____Obstructive Sleep Apnea
____Periodic Limb Movement Disorder	____Restless Leg Syndrome
____Narcolepsy	____Idiopathic Hypersomnia
____Insomnia	

PHYSICIAN SIGNATURE: _____ DATE: _____

Follow-up: _____will be done by me ____Please schedule consultation with _____

255 Lafayette Avenue, Suffern, New York 10901 **Tel:** 845/368-5510 Fax: 845/368-5516 **Good help to those in need.**