Children's Healthcare of Atlanta
Sleep Disorders Laboratory Order Form

Please print clearly

Child's name: _____ Sex: ☐ M ☐ F Child's DOB: _____

Children's MRN (if known): _____ Parent/Guardian's Name: _____

Address: _____

Primary phone: _____ Alt. phone: _____ Email: _____

Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Ordering physician: _____ Office phone: _____ Fax:_____

Primary care physician (if not the ordering physician): _____

Source: ☐ Office ☐ TDPC ☐ Craniofacial ☐ MDA ☐ Sickle cell ☐ Other: _____

Previous study: ☐ No ☐ Yes If Yes: ☐ Children's Healthcare of Atlanta ☐ Other: _____

Reason for study: _____

List signs/symptoms, do not use "rule out," "probable," "suspected," etc.

ICD-10 Code (sleep related; required) Check all that apply: ☐ R06.83 (snoring) ☐ G47.33 (obstructive sleep apnea) ☐ G47.36 (hypoxemia) ☐ other(s) _____

Other medical problems: ☐ Down Syndrome ☐ ADHD ☐ Autism ☐ Sickle cell ☐ Tracheostomy ☐ Obesity

Insurance company:_____ Group/ID #:_____

Pre-certification/authorization number:_____

If pre-certification is required by insurance, please obtain and fax the authorization to us no later than one week before the test date.

Evaluation Requested: (for explanation, visit choa.org/sleep or call us)

☐ **Nocturnal Polysomnogram** (CPT code 95810 if > 6 yrs or 95782 if < 6 yrs of age)

This is a complete overnight study that includes sleep staging and respiratory parameters

☐ Check here if you would like us to order O2 (if needed) and provide consultation/follow up

☐ Cardiology patients: Provide the child's baseline/expected SpO2 _____

☐ **CPAP or Bi-level PAP titration** (CPT code 95811 if > 6 yrs or 95783 if < 6 yrs of age)

CPAP/BPAP titration order form required; a sleep medicine or pulmonology consult is recommended

☐ **Multiple Sleep Latency Test (MSLT)** (CPT code 95805)

Nap study for narcolepsy; must also order the Nocturnal Polysomnogram above

A sleep medicine consult is required before an MSLT unless previously evaluated by a neurologist

Special study requests and/or special needs of the child: _____

_____

We will schedule the study at the Children's Sleep Laboratory that is best for the family and the parameters requested.

Ordering physician signature: _____ **Date:** _____

Please print name clearly: _____

Fax form to 404-785-2211

Questions: Contact Central Scheduling at 404-785-2974 or **sleepcenterschedulingoffice@choa.org**

Visit **choa.org/sleep** for more information or to print additional forms. Visit **choa.org/accessCHOA** to sign up for accessCHOA.