Westside Regional Medical Center
Sleep Disorder Center
Patient Demographic Record and Order

Please fill out **all information** ***OR*** fax Patient Demographic Information with this form:

Patient Name:_________________________________DOB:____________SS#_____________________

Address:____

City:____State:__________Zip Code:__________________

Phone:(H)________________________(W)________________________(Cell)_______________________

Primary Insurance:___________________Policy#____________________Group#_____________________

Authorization#_____________________________ Ordering Physician:______________________________

Primary Physcian:______________________________Phone:__________________Fax:________________

PHYSICIAN ORDER (this area MUST be completed)

Please circle appropriate test:

BASELINE STUDY	**SPLIT STUDY (Tech Discretion)**	**CPAP/BIPAP**
(95810)	(95811)	(95811)

PATIENT DIAGNOSIS:____

Hypersomnia with sleep apnea	Restless legs	PLMs	Narcolepsy	Other & unspecified apnea	Insomnia with apnea
(780.53)	(333.94)	(327.51)	(347.00)	(780.57)	(780.51)

Night Terrors	Other Hypersomnia	Phase-shift disruption of 24 hour sleep-wake cycle	Repetitive intrusions of sleep
(307.46)	(780.54)	(307.45)	(307.48)

Special Instructions:____

ORDERING PHYSICIAN SIGNATURE:______________________________________**DATE:**___________

PHONE#____FAX#___________________________________

Please fax to Sleep Disorders Center at 954-452-2157 or 954-916-5446
with a front and back copy of **insurance card.**

Thank you.

For office use only:

Scheduled testing date:____________________

Correspondence:____

This form will be faxed back to you once the patient has been scheduled.