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:

Arthur M. Blank Hospital Sleep Center Satellite Boulevard Sleep Center Scottish Rite Hospital Sleep Center

Interpreting group for this study (each of our sleep specialists can interpret studies performed at any location):

□ Arthur M. Blank Hospital-based sleep physicians: Roberta Leu, Amit Shah, Daniel Torrez

□ Scottish Rite Hospital-based sleep physician: Sophia Kim

The ordering physician must choose the interpreting group and send clinical notes before we can schedule the study.

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

Please print name clearly: _____

Fax this form and history/clinical notes to 404-785-2211

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