LETTER OF MEDICAL NECESSITY

Sleep Diagnostics Center

LABEL

Outpatient Order Form

Date ______________________

Patient's Name _____________________________________ Home phone number ____________________________
Address ____ Work phone number _____________________________
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DOB: ____ SS# ____

To whom it may concern:

____________________________________ is a patient at our facility and has reported symptoms of poor sleep history with complaints of:

_____ snoring
_____ waking up gasping for air
_____ unable to sleep through the night
_____ falling asleep while driving
_____ hypertension
_____ sleep walking
_____ frequent sore throats
_____ inability to fall asleep
_____ sleep apnea
_____ hypersomnia
_____ excessive leg movements during the night
_____ falling asleep at inopportune times
_____ losing sex drive
_____ nightmares
_____ night coughing and wheezing
_____ leg pain during the night
_____ fatigue

Physician Signature ____

Office Name ____

Office Phone ____

Patient Name ____ Date __________________

Account # ____ Doctor ______________________________

Sleep Center **PLEASE CIRCLE**

Polysomnogram, MSLT needed

Polysomnogram, no MSLT needed

Polysomnogram seizure montage

Polysomnogram with Etc02

CPAP/Bipap titration no MSLT

CPAP/Bipap titration MSLT mandatory

Comments

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