NEUROCARE SLEEP CENTER

4105 Holiday St. N.W. P.O. Box 35006, Canton, Ohio 44735
Phone 330.244.2500 • Fax 330.244.2510

Name: First ________________________________ MI _________ Last ______________________________
SS#: ____ DOB: _____________________________________
Address: ____
City: ____ State: __________ Zip: _________________________
Phone: Home: ________________________________ Work: ______________________________________
Weight: _______________________ Height: ____________________ Marital Status: __________________

Sleep study and treatment (as needed) ordered:
Canton Office ______________ Alliance Office ____________ Aultman Orrville Office ______________
PSG (95810)/consult ________ PSG (95810) only _____ HST (95800)/Consult ________
CPAP titration (95811)/consult _______ CPAP Titration (95811) only _______ Consult Only _________
MSLT (95805)/consult ______ MSLT (95805)/ only ______
MWT (95805) /consult _______ MWT (95805)/ only _______
OSA _______ Narcolepsy _______ PLMS/RLS _______ Insomnia _______ **Pre -OP Assessment _________**
Other (please describe): ____ **Surgery Date ______________**
Symptoms: Witnessed Apneas ____________ Snoring _____________ Daytime Somnolence _______________

Reading Physician: NeuroCare ___________
Other (qualified sleep physician): ____

Medications: include all medications, including antidepressants, hypnotics, cardiac, and diabetic meds:
____
Is patient a diabetic? Yes ______ No ______ Drug or environmental allergies: ________________________

Referring Physician: ___________________________________ Phone: ______________________________
Address: ____ City: _________________________________
State: ____________________ Zip: ______________________ Fax: __________________________________

Physician Signature: ____

Primary Insurance Information: Insured's Name: ____
Name of insurance: ___________________________________ DOB: ________________________________
Employer: _____________________________________ Insurance Phone #: ___________________________
ID #: ____ Group #: ____________________________________

Secondary Insurance Information: Insured's Name: ____
Name of insurance: ___________________________________ DOB: ________________________________
Employer: _____________________________________ Insurance Phone #: ___________________________
ID #: ____ Group #: ____________________________________

**** Please include medical history (current dictation), copy of insurance cards and preauth notes for studies ordered****