AULTMAN ORRVILLE HOSPITAL

832 South Main Street * Orrville, OH 44667
Phone (330) 682-3010, ext 182 * 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:

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 Physican: NeuroCare _____ Robert Sibilia, MD _____
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 preauthorization notes for testing ordered.****