Palmetto Pulmonary Medicine, P.A.
Sleep Disorders Center

989 Ribaut Road, Suite 340
Beaufort, SC 29902

Phone: 843-521-8484
Fax: 843-521-8485

Physicians:

Direct Referral into Sleep Lab

In order to speed up sleep apnea evaluations and decrease sleep lab wait times, patients must meet one of the following criteria and must be documented in the patient's progress note.

- Witnessed apneic events while sleeping
- Excessive daytime sleepiness (defined as an Epworth sleepiness scale score of >10)
- Unexplained hypertension or arrhythmia
- Symptoms suggestive of narcolepsy (e.g., sleep paralysis, hypnagogic hallucinations, cataplexy)
- Pronounced snoring or disrupted sleep
- Or Stop/Bang Score of yes to 3 or more questions.

During the Physical Exam the following vitals must be documented:

- Neck Size
- BMI
- Height
- Weight

Other clinical criteria that should be addressed include

- Does the patient have uncontrolled hypertension?
- Does the patient snore?
- Does the patient snort while sleeping?
- Does the patient gasp or choke while sleeping?

Please complete the attached diagnostic testing request form and we will perform the sleep study and see the patient back in our office to review sleep results and management options.

Thank you for your assistance in addressing these important steps. We look forward to scheduling your patient into the lab. Please feel free to call Judy with any questions at 843-521-8494.

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DIAGNOSTIC TESTING REQUEST FORM

Patient Name_____ DOB_____

Address _____

Phone _____Social Security#_____

Insurance Please provide copies of insurance cards

Neck Size _____ Height _____ Weight _____ BMI _____

Physician Name _____

NPI # _____

Address: _____

Phone# _____ Fax# _____

Referral Contact _____

INDICATIONS FOR SLEEP TESTING
(check all that apply)

☐ G47.33 Observed apneas/Witnessed Breathing Pauses
☐ G47.10 Excessive Daytime Sleepiness/Hypersomnia
☐ G47.30 Central/Complex Apnea
☐ E66.01Obesity or Significant Weight Gain
☐ R06.83 Snoring ☐ Narcolepsy ☐ G47.30 Habitual Choking, Gasping, or Night Sweats ☐ Snort
☐ G47.61 Excessive or Abnormal Body/Limb Movements ☐ Other _____
☐ I10 Hypertension ☐ Other _____

SCREENING FOR OBSTRUCTIVE SLEEP APNEA

STOP

S (snore)	Have you been told you snore?	Yes / No
T (tired)	Are you often tired during the day?	Yes / No
O (Obstruction)	Do you know if you stop breathing?	Yes / No
P (pressure)	Do you have high blood pressure or are you on medication to control high blood pressure?	Yes / No

BANG

B (BMI)	Is your body mass index >28?	Yes/No
A (age)	Are you 50 years old or older?	Yes/No
N (neck)	Are you a male with a neck circumference >17", or a female with a neck circumference >16"?	Yes/No
G (gender)	Are you a male/female	Yes/No

TYPE OF TESTING REQUESTED

☐ 95810 Adult Polysomnography (PSG) in lab
☐ 95811 CPAP titration study (requires a copy of previous PSG)
☐ 95806 Home Sleep Test

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tried? This refers to your usual way of life in recent times. Event if you have not done some of these things recently, try to work out how they would have affected you. Choose the most appropriate number for each situation.
0 = would never fall asleep
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting in a public place (i.e. theatre, meeting)	_____
As a passenger in a care for an hour w/o break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch w/o alcohol	_____
In a care, while stopped for a few mins in traffic	_____
Total	_____

PLEASE BE SURE TO INCLUDE THE FOLLOWING WITH THIS FORM:
Clinical Notes/Insurance Info/Demos/Med List

Physician Signature_____ Date_____ Reviewed: 11/18