COMPLETE HEALTH
Sleep Diagnostics • Home Medical Equipment

(770) 777-1868
(888) 545-6005
Fax (770) 777-1872

Letter of Medical Necessity

Instructions: Complete this form in its entirety and along with the Patient's Information Sheet and Insurance Card, fax to (770) 777-1872.

Section 1 - Patient Information

Patient Name: ____________ **SSN:** ____________ **DOB:** ____________
Home Phone: ____________ **Work Phone:** ____________ **Cell Phone:** ____________
Height: ____________ **Weight:** ____________ **B/P:** ____________

Section 2 - Clinical Observations and Physical Findings

Symptoms of Sleep Disorders:

- ❑ Excessive daytime somnolence
- ❑ Loud, irregular snoring
- ❑ Observed apnea
- ❑ Awakening & gasping for breath
- ❑ Un-refreshing sleep
- ❑ Frequent awakenings
- ❑ Morning headache
- ❑ Cataplectic attacks
- ❑ Loss of sex drive/motivation
- ❑ Overwhelming episodes of sleep
- ❑ Restless, jerking legs during sleep
- ❑ Sleep paralysis

Physical Findings and Medical History:

- ❑ Enlarged tonsils
- ❑ Enlarged tongue
- ❑ Posteriorly displaced tongue
- ❑ Retrognathia / micrognathia
- ❑ Nasal Obstruction (septal deviation or turbine hypertrophy)
- ❑ Crowded oropharynx
- ❑ Crowded hypopharynx
- ❑ Large neck circumference
- ❑ Obesity / weight gain
- ❑ Hypertension
- ❑ Heart disease
- ❑ COPD
- ❑ Asthma
- ❑ Epilepsy
- ❑ Active infectious disease
- ❑ Other: ______________________

Section 3 - Preliminary Diagnosis

❑ Obstructive Sleep Apnea -OSAS (780.53) ❑ Narcolepsy (347) ❑ Other:

Section 4 - Study Order Information

❑ Polysomnogram (Sleep Study)	95810	❑ MWT (Wakefullnes Test)	95805
❑ CPAP Titration	95811	❑ MSLT (Narcolepsy Test)	95805

❑ **Two Night Protocol** (Polysomnogram 95810 **AND** CPAP Titration IF RDI > 15, OR RDI is between 10 & 15 with appropriate secondary symptoms.)

❑ Post Surgical Polysomnogram 95810 (Date of Surgery: __________________)

❑ Patient is on Oxygen @ _______ LPM

❑ Special Instructions: ____________

Section 5 - Medications

PLEASE INDICATE BELOW THE MEDICATIONS THAT YOUR PATIENT MAY SELF ADMINISTER IF REQUESTED

- ❑ acetaminophin (e.g. Tylenol) 325 mg Dosage: 1-2 caplets PO Frequency: Every 4-6 hours as necessary for headache
- ❑ oxymetazoline HCI (e.g. Afrin) 0.05% Nasal Spray Dosage: 2-3 sprays per nostril Frequency: as needed for nasal congestion
- ❑ Aluminum, Magnesium, and Simethocone Liquid, 200/200/20 (e.g. Mylanta, Maalox) by mouth Dosage: 30mL PO Frequency: Every 4-6 hours as necessary for indigestion
- ❑ diphenydramine Hydrochloride, 25mg Dosage: 1 tablet PO as a sleep aide, after patient has been unable to fall asleep for one hour, if unable to fall asleep 30 minutes after administration, a second dose may be given. This medication may only be adminstered during the first 2 hours of testing.
- ❑ zolpidem tartrate (e.g. Ambien), as prescribed by referring physician **NOTE: THIS MEDICATION IS NOT KEPT IN THE SLEEP CENTER**

- ❑ CURRENT MEDICATIONS: ____________
- ❑ **This patient is deemed competent to self administer the medications checked above.**

PHYSICIAN SIGNATURE: ____________ **DATE:** ____________
Print Physician Name: ____________ UPIN #: ____________
Physician Phone: ____________ Office Contact Name: ____________