



Leading-edge testing ~ Patient-centered care

Sleep Medical Centers

Durham, Burlington, Jacksonville

Second Breath

Oxygen, CPAP/BiPAP, Nebulizers

Ph: 919-477-1588 or 866-499-1588

Fax: 919-477-1688 or 866-499-1288

Website: www.FeelingGreatSleepCenter.com

PATIENT INFORMATION

Name _____ Gender () M () F Date of Birth _____
 Address _____ City _____ State _____ Zip _____
 Social Security # _____ Marital Status () Married () Single () Divorced
 Home Ph: _____ Cell Ph: _____ Work Ph: _____
 Diagnosis _____ Email _____
 1st Ins _____ Policy # _____ 2nd Ins _____ Policy # _____

CERTIFICATE OF MEDICAL NECESSITY – PRESCRIPTIONS

SLEEP STUDY

PSG (), CPAP/BiPAP (), MSLT (), MWT (), Split ()

Evaluation needed to determine:

R/O OSA (), Narcolepsy – PSG & MSLT (), HTN (),
 H/O CVA (), H/O CHF (), Severe Snoring (),
 Hypersomnia / Excessive Daytime Sleepiness (),
 Sleep Disturbance (), Other _____

If patient's PSG is positive for OSA, may we proceed
 with the titration study? Yes _____, No _____

SLEEP PHYSICIAN CONSULTATION

Sleep Specialist Office Consultation ()

- Evaluate Patient Prior to Sleep Study ()
- Follow-up after Sleep Study ()

Evaluation needed to assess / treat:

Sleep Apnea (), Insomnia (), Narcolepsy ()
 Epilepsy (), Night Terrors (), REM Disorders ()
 Restless Legs (),
 Other () _____

CPAP/BiPAP

New machine () CPAP () BiPAP ()
 Old machine upgrade () Titration change ()
 Mask / supplies () Other () _____

Dx if AHI 15 or >: ___ OSA (780.53), ___ COPD (496)

If AHI is between 5 and 14,
 indicate a secondary diagnosis of:
 ___ EDS, ___ HTN, ___ Insomnia, ___ h/o CVA
 Other _____

CPAP @ _____ cm H2O

BiPAP-S @ I _____, E _____ cm H2O

BiPAP-ST @ I _____, E _____ cm H2O
 _____ bpm back-up rate

Humidity Yes (), No () Heated (), Cool ()

OXYGEN

Dx: COPD - 496 (), CHF – 428.0 (), Other _____

Home Oxygen: _____ Portable Needed: Yes (), No ()

Room Air O2 Sat: _____ (qualifying < 88%) Date: _____

RA Sat done at: Within 2 days of Hosp D/C (), Home ()
 Physician's Office (), Other _____

O2 treatment @ _____ LPM via nasal cannula, _____ hours

Continuously _____, with sleep only _____

Estimated Length of Need: _____ 99 = Lifetime, Other _____

Standard Continuous Flow Regulator _____

Conserving Device Regulator _____ (MD ensures sats > 90%)

Print MD Name _____ Group Name _____
 Address _____ Email _____
 Phone # _____ Fax # _____

I certify that I am the treating physician. I have completed this Certificate of Medical Necessity form and any statements here have been reviewed and signed by me. I certify that the medical information is true, accurate, and complete to the best of my knowledge. I certify that the above test / equipment ordered are medically necessary in the treatment of this patient.

Physician Signature _____ NPI # _____ Date _____