



A PARTNERSHIP ST. LUKE'S HOSPITAL • MERCY MEDICAL CENTER • PCI

**EASTERN IOWA SLEEP CENTER**

600 7TH STREET SE • CEDAR RAPIDS, IA 52401  
PHONE.319.362.4433 • TOLLFREE.877.361.4433  
FAX.319.362.4466

**HANAK  
TO  
READ**

*EISC Use Only!*

\_\_\_\_\_  
Patient's Scheduled Date/Time

\_\_\_\_\_  
EISC Approval/Date

IF A SLEEP MEDICINE CONSULTATION IS NECESSARY, PLEASE CONTACT PCI NEUROLOGY AT 319.398.1721 DIRECTLY FOR SCHEDULING.

**PATIENT PERSONAL INFORMATION**

Name: \_\_\_\_\_

Address/City/State/Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Birth date: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender: M F Occupation \_\_\_\_\_

Sleeping hours: From \_\_\_\_\_ To \_\_\_\_\_ Night \_\_\_\_\_ Day \_\_\_\_\_ Evening \_\_\_\_\_

**INDICATIONS & TYPE OF TESTING REQUIRED**

**Sleep Disordered Breathing**

780.57 Sleep Apnea NOS  
*unless otherwise indicated at right*

|  |   |
|--|---|
| <input type="checkbox"/> 327.23 Obstructive Sleep Apnea            | <input type="checkbox"/> 780.55 Disruption of 24 hr Sleep Wake Cycle NOS                        |
| <input type="checkbox"/> 780.09 Alteration of Consciousness, Other | <input type="checkbox"/> 780.56 Dysfunctions associated with Sleep Stages or Arousal from Sleep |
| <input type="checkbox"/> 780.51 Insomnia with Sleep Apnea          | <input type="checkbox"/> 786.09 Snoring & other Respiratory Abnormality NOS                     |
| <input type="checkbox"/> 780.53 Hypersomnia with Sleep Apnea       | <input type="checkbox"/> 799.02 Hypoxemia   |
| <input type="checkbox"/> 780.54 Hypersomnia NOS                    |   |

*Diagnostic polysomnogram with split night or second night titration, if indicated*

*Diagnostic polysomnogram only, no additional testing*

*PAP (re)titration with CPAP or BiPAP (including autoSV or AVAPS)* Previous study done at: \_\_\_\_\_

*Please monitor PCO2 during the above testing* Ref: Medicare Carriers manual; Transmittal #1725; 9/27/01

**Narcolepsy & Hypersomnia**

347.01 Narcolepsy with Cataplexy  
*unless otherwise indicated at right*

|   |  |
|---|--|
| <input type="checkbox"/> 347.00 Narcolepsy without Cataplexy                                    | <input type="checkbox"/> 347.11 Narcolepsy with Cataplexy in conditions classified elsewhere |
| <input type="checkbox"/> 347.10 Narcolepsy without Cataplexy in conditions classified elsewhere | <input type="checkbox"/> 780.53 Hypersomnia with Sleep Apnea                                 |
|   | <input type="checkbox"/> 780.54 Hypersomnia, Unspecified                                     |

*Diagnostic polysomnogram with Multiple Sleep Latency Testing*

**Parasomnia**

Please indicate diagnosis at right

|  |   |
|--|---|
| <input type="checkbox"/> 345.8* Epilepsy and Recurrent Seizures, with/without intractable seizures | <input type="checkbox"/> 780.56 Dysfunctions associated with Sleep Stages or Arousal from Sleep (RBD) |
| <input type="checkbox"/> 780.09 Alteration of Consciousness, Other                                 | <input type="checkbox"/> 780.58 Sleep related Movement Disorder NOS                                   |
| <input type="checkbox"/> 780.55 Disruption of 24 hr Sleep Wake Cycle NOS                           | <input type="checkbox"/> 780.59 Other Sleep Disturbances  |

*Diagnostic polysomnogram with extended EEG monitoring*

**Wakefulness Testing** With concerns about the patient's ability to remain awake with ongoing or past treatment

*Maintenance of Wakefulness Test*  *Diagnostic polysomnogram with Multiple Sleep Latency Testing*

PLEASE CONVERSE WITH A SLEEP MEDICINE PHYSICIAN IF IT IS NOT CLEAR WHICH STUDY IS MOST APPROPRIATE FOR YOUR PATIENT.

**PHYSICIAN INFORMATION** \*Dr. Viktor Hanak to read

Referring Physician \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

PCP: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

IF YOU HAVE PROVIDED YOUR PATIENT WITH A SLEEP AID, PLEASE INSTRUCT THEM TO BRING THE FILLED PRESCRIPTION WITH THEM TO THE SLEEP CENTER. THE SLEEP TECHNICIAN WILL INFORM YOUR PATIENT WHEN THE SLEEP AID SHOULD BE TAKEN.

Referring Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

