dell children's
medical center of central texas
A member of the Seton Family of Hospitals

Sleep Lab Order Form

Fax Completed Form to (512) 380-0552
Phone (512) 324-1199

Business Hours for Scheduling:
Monday-Friday 0800-1600

Requested Study (Please check one)*

- ☐ Baseline Diagnostic (95810)
- ☐ Baseline / Diagnostic <6yr (95782)
- ☐ Oxygen (specify LPM___)(95810)
- ☐ Uncapped Trach (95810/ 95782)
- ☐ CPAP Titration (95811)
- ☐ CPAP Titration (95783) < 6yrs
- ☐ Capped Trach (95810/ 95782)
- ☐ Bi-level PAP Titration (95811)
- ☐ Bi-level PAP Titration <6yr (95783)
- ☐ MSLT (95805)

**All studies subject to medical director review. Please consider consultation if ordering a study other than a baseline / diagnostic or oxygen polysomnogram. Orders for studies other than baseline and oxygen will be reviewed by the sleep physician and additional information may be required before it can be scheduled.*

Patient Contact	Physician Contact
Name:	Ordering Physician:
DOB:	Office Phone:
Phone :	Office Fax:
Parent Name	Physician contact during night of the study:
Patient email contact:	Other contact information

***Patients are admitted to the sleep lab as outpatients. The physician ordering the study is thus responsible for any patient care issues that may arise during the study. Please provide a pager or answering service where you or a representative of your offices can be reached at all times during the study should any questions arise. If you would like the patient to be managed by our sleep physician during the study then consultation needs to be arranged before the study is performed by calling the number above.*

If you would like this report sent to any other physicians, please provide a complete contact information:
Name_____ Phone / Fax Number:_____

To ensure we have appropriate resources, please check all that apply *(give details in patient information below):*

- ☐ Oxygen
- ☐ Feeding Tubes
- ☐ Mobility Issues
- Developmental Delays
- ☐ Full Montage EEG
- ☐ Vent / CPAP
- ☐ Infant

Patient Information

Insurance Name and Policy #:	Pre- Authorization # (if indicated):	Date of Study:
Reason for Study: (Patient History / Symptoms) Please include ICD codes:		
Patient Current Oxygen, CPAP, Bi-Level, or Ventilator Settings: If baseline is ordered above, study will begin on room air and O2 added per protocol (Performing studies on O2 may underestimate the degree of OSA)		
Special Procedure / Requests: ☐ **CBG request for patients with a history of hypoventilation and /or performing an oxygen, CPAP, or Bi-livel titration** **-PRN CBG to be performed according to protocol below if not indicated. PRN CPG is to be performed in the event Transcutaneous CO2 monitor utilized**		
***All items, including determination of oxygen, non-invasive and invasive ventilation titration will be performed by standard protocols unless specifically outlined in the special procedure / request section above. If you have any questions about whether the standard protocol is appropriate for your patient's specific condition, you should complete the section above. Copies of the protocols are available upon request. Oxygen Protocol: Oxygen will be added if SpO2 drops below 85% for more than 5 min and will be titrated to the lowest flow possible to keep SpO2 at least 92%. If higher than standard SpO2 or oxygen requirements or other parameters are needed, please specify. CBG will be performed if ≥10% of a minimum 3hr total sleep time displays ETCO2 or TcCO2 values of greater than 60mmHg.*		

Physician Signature_____ **Date**_____