

MARYLAND GENERAL HOSPITAL

Centralized Scheduling Telephone: 410-225-8083 Fax: 410-552-2855

SLEEP STUDY INTAKE FORM

Patient Information		
Last Name:	First:	MI:
Address:		
City:	State:	Zip Code:
Home Phone :()	Work Phone :()	
Date of Birth: / /	Social Security: - -	
Nearest Relative/POA:	Telephone: ()	

Primary Insurance Information		
Company Name:		
Policy Holder:	Relationship:	D.O.B: / /
Employer:		
Member/Policy/ID#:	Group#:	
Authorization # (if required):		

Secondary Insurance Information		
Company Name:		
Policy Holder:	Relationship:	D.O.B: / /
Employer:		
Member/Policy/ID#:	Group#:	
Authorization # (if required):		

Test Ordered	Clinical Indication	
<input type="checkbox"/> PSG 95810	<input type="checkbox"/> Witnessed Apnea	<input type="checkbox"/> Restless Sleep
<input type="checkbox"/> Split Night 95811	<input type="checkbox"/> Excessive Daytime Sleepiness	<input type="checkbox"/> Enlarged Tonsils
<input type="checkbox"/> CPAP/BiPAP 94660	<input type="checkbox"/> Obesity	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Re-titration	<input type="checkbox"/> Snoring	<input type="checkbox"/> Diagnosed OSAS
<input type="checkbox"/> MSLT 95805	<input type="checkbox"/> Morning Headaches	<input type="checkbox"/> Other _____
<input type="checkbox"/> MWT 95805	<input type="checkbox"/> Poor Attention	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Irritability	<input type="checkbox"/> Other _____

Ordering Physician Name/ Signature: _____

Request Completed By: _____ Telephone () _____-_____

Appointment Date: _____/_____/_____