NEWTON-WELLESLEY HOSPITAL

General Pre-Authorization Form

(To accompany Sleep Center Order Form)

The NWH Sleep Center is pleased to obtain pre-authorization for Sleep Studies when your patient has one of the following insurance types: ***BCBS, Harvard Pilgrim, Tufts or United.*** *To pursue pre-authorization, we will need a completed copy of this form and the Sleep Center order form. Please fax both documents to* ***(617) 243-6776*** *If we are unable to obtain pre-authorization approval then we will notify you.*

Patient Name_____ **DOB**_____/_____/_____ **Age**_____

Insurance Plan (circle): **BCBS** **Harvard Pilgrim** **Tufts** **United**

PT Insurance Member # _____ **Home Phone** _____ **Cell**_____

Requesting Physician _____ **Requesting Physician NPI** _____

Requesting Physician Phone_____ **Fax**_____**Address**_____

Order Type	If you are requesting an In-Lab Study (PSG) and **Contraindications*** to a Home Sleep Study are not present, do you want to switch to a Home Sleep Study? Yes ____ No ____		
Has this patient had a previous sleep study? Yes ___ No ___ ***If yes, fill out all info. including the shaded and nonshaded boxes. If no, only populate the non-shaded boxes.**			
Reason for a Follow-Up Diagnostic Study	**Questions – Please check all that apply** ☐ Significant weight loss (defined as 10% of body weight) since the most recent study ☐ To evaluate the outcomes of surgery (including removal of tonsils or oropharyngeal surgery) ☐ To evaluate outcomes of oral appliance / device ☐ Previous technically suboptimal home study (2 nights) ☐ Previous two night home study which did not diagnose OSA in patient with ongoing clinical suspicion of OSA ☐ Other: _____		
Repeat Study Indication			
What was the date of the prior sleep test?			
What type of study was done?	☐ Diagnostic Polysomnogram ☐ Home Sleep Test ☐ Attended Titration Study ☐ Attended Split Night Study		
What is the reason for repeat testing?			
Has the member been compliant with their PAP therapy?	☐ Yes ☐ No		
Category	**Questions – Please check all that apply**		
Apnea Events	The patient has observed apnea during sleep: Yes ___ No ___ Unknown ___		
Signs and Symptoms	☐ Excessive daytime sleepiness evidenced by: ◊ Inappropriate daytime napping (during conversation, driving or eating) or, ◊ Sleepiness that interferes with daily activity ☐ Habitual snoring, or, gasping/choking episodes associated with awakenings ☐ Unexplained hypertension ☐ Soft tissue abnormalities or neuromuscular diseases involving the craniofacial area or upper airway ☐ Obesity ◊ BMI > 30 ◊ Patient Height _____ Patient Weight _____ ◊ Neck circumference > 17" for males and >16" for females		
	◊ Non- restorative sleep	◊ High Blood Pressure	◊ Decreased Libido
	◊ Irritability	◊ Memory Loss	◊ Nocturia
	◊ Patient works night shift	◊ Disturbed or restless	◊ Frequent unexplained

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		sleep	arousals
	◊ Sleeps < 6 hours	◊ Non-ambulatory	◊ RLS / PLMS
Duration of Symptoms	**How long has the patient been experiencing their symptoms?**		
	☐ < One Month ◊ (# weeks__)	☐ One Month	☐ Three Months	☐ Six Months
Comorbid Conditions and Contraindications to a Home Study • **Recent Supporting office notes required**	☐ Stroke (CVA) within the last 30 days ☐ History of stroke or myocardial infraction. When? ___/___/___ ☐ Transient Ischemic Attack (TIA) ☐ Coronary Artery Disease (CAD) ☐ Sustained Supraventricular Tachycardiac Arrhythmias ☐ Sustained Supraventricular Bradycardiac Arrhythmias ☐ Idiopathic **Pulmonary** Hypertension (NOT high blood pressure) ☐ Suspected nocturnal seizures ☐ Suspected Narcolepsy ☐ Central Sleep Apnea (CSA) ☐ Moderate or Severe Chronic Obstructive Pulmonary Disease (COPD) (III or IV) ☐ Severe congestive heart failure (NYHA Class III or IV) ☐ Oxygen dependent for any reason ☐ Cognitive impairment (unable to follow simple instructions) ☐ Neuromuscular impairment; needs assistance for activities of daily living ☐ Sustained ventricular tachycardia ☐ The patient is 18 years old or younger		
Duration of Symptoms	**How long has the patient presented with their co-morbid condition?**		
	☐ < One Month ◊ (# weeks__)	☐ One Month	☐ Three Months	☐ Six Months
Medications • **Please list**			

Epworth Sleepiness Scale

Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze or sleep

1 = Slight chance of dozing or sleeping

2 = Moderate chance of dozing or sleeping

3 = High chance of dozing or sleeping

Situation Chance of Dozing or Sleeping	**Scale**
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (without alcohol)	
Sitting for a few minutes in traffic while driving	
Total Score equals your ESS	

0-9 = Average score, normal population

*A contraindication is a condition that makes a particular procedure or test inadvisable.