Orlando Sleep Medicine
Sleep Medicine Specialists
KAREN BAKER, M.D.

Sleep Request

Phone 407-794-8000, fax 877-409-1295

Patient Information

Today's Date _____

Last Name_____, First Name_____Middle Initial_____

Address_____City_____State: _____Zip: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female ☐ Other preference

Height: _____feet ___inches Weight: _____lbs. Neck Size: _____inches

Email Address_____

☐ Cell Phone_____☐ Home Phone_____ ☐ Work Phone_____

Patient Preferred Location for Sleep Study

☐ Orlando ☐ Altamonte ☐ East Orlando ☐ Apopka ☐ Clermont ☐ St. Cloud ☐ Deland

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Diagnostic Test & Requested Procedures

☐ 95810 – Baseline Polysomnogram
☐ 95811 – CPAP/BiPAP Titration
☐ 95811 – BiPAP Auto SV (patient must have diagnosis of central sleep apnea to qualify)
☐ 95805 – MSLT (patient required to have consultation with specialist prior to scheduling study)
☐ 95806 – Home study
☐ 99204 – New patient sleep evaluation

Diagnosis: _____

Ordering Provider Information—*notes detailing sleep problem must accompany order*

Name:_____**NPI:**_____

Contact:_____ **Phone Number:**_____

Physician Signature:_____

Study will be read by Karen Baker, MD

Fax this form to 877-409-1295