

**Our Physicians:**

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**Our Locations:**

*(main location)*  
1700 Ygnacio Valley Rd, Ste 100  
Walnut Creek, CA 94598  
*(satellite location)*  
350 John Muir Pkwy, Ste 175  
Brentwood, CA 94513

**SLEEP CENTER ORDER FORM**

\*\*\*\* Please fax patient's history and physical and insurance info (enlarged copy of cards). We will verify benefits. \*\*\*\*

Name \_\_\_\_\_ DOB \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ SS# or Subscriber ID # \_\_\_\_\_  
Insurance Type: HMO PPO POS EPO Other: \_\_\_\_\_

**CONSULTS AVAILABLE:**

- New Patient Sleep Consultation:** New Patient evaluation for possible sleep disorder with Sleep Physician
- Follow-Up Consultation:** Sleep Physician will review PSG and treatment options with patient after initial sleep study
- Oral Appliance Consultation:** Review oral appliance treatment options with Sleep Dentist

**SLEEP STUDIES AVAILABLE:**

- PSG with CPAP titration (Standard Test)** (CPT-95811) Diagnostic sleep study with CPAP pressure determination
- Polysomnography (PSG)** (CPT-95810) Diagnostic sleep study only (NO CPAP Titration)
- CPAP titration study** (CPT-94660) All night CPAP titration
- BiLevel titration study** (CPT-94660) All night BiLevel titration
- Multiple Sleep Latency Test (MSLT)** (CPT-95805) Daytime nap study to rule out or diagnose narcolepsy
- Maintenance of Wakefulness Test (MWT)** (CPT-95805) Daytime wake study
- Nocturnal Pulse Oximetry study** (CPT-94762) Overnight oximetry monitoring
- Oral Appliance titration** (CPT-95811) All night Oral Appliance titration
- Special Instructions:** \_\_\_\_\_

**We will offer a sleep aid in the form of Ambien to patients who are having difficulty falling asleep, unless you, their physician, order to the contrary. Ambien does not interfere with sleep architecture. If you do not want Ambien to be given to your patient, please check here.**

The above referenced patient has an absolute medical necessity for the item(s) listed above, based on the following diagnosis:  APNEA  Other: \_\_\_\_\_. I certify that the above prescribed item(s) is/are medically indicated and in my opinion is/are reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.

Physician \_\_\_\_\_ Specialty \_\_\_\_\_ NPI # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_ Office Contact \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_