Saint Alphonsus
A Member of Trinity Health

AFFIX PATIENT LABEL OR WRITE
Patient's Name: _____
Date of Birth: _____
Today's Date: _____

Sleep Disorders Center Outpatient Order Form (Adults) -- SAHS-2146

Boise | Nampa | Meridian | Ontario
Phone: 208-367-2008 | Fax: 208-367-6053

Baker City
Phone: 541-524-7831 | Fax: 541-524-7832

Patient Name	DOB	Patient Phone
Provider Name (printed)	Diagnosis / Indications *	
Provider Signature (required)	Prior Authorization (required for sleep study)	
Date	Scheduling Notes	

*Diagnosis must meet medical necessity for sleep study. For a complete list of diagnosis codes, please visit the CMS website at cms.gov. Most commonly used are G47.33- Obstructive Sleep Apnea, G47.30 Sleep Apnea, and G47.10- Hypersomnia

Please send relevant Clinical Notes and Demographics

☐ Sleep Consult – Sleep MD to order testing if indicated (fax to 208-302-3355)
☐ Sleep Study Only- Referring Provider to provide follow up and management
☐ Pediatric Consult- Sleep MD to order testing if indicated (fax to 208-302-3355)

Testing (complete this section if ordering sleep study only)

☐ Home Sleep Study (CPT 95806)
☐ Diagnostic PSG (CPT 95810)
☐ Split Night PSG (CPT 95811) - start as PSG and move to titration if positive per lab protocol
☐ Titration (CPT 95811) – circle below
CPAP BiLevel ASV Other instructions _____

Special Needs:

☐Supplemental oxygen _____ L/min
☐Carbon Dioxide Monitoring
☐Needs Interpreter
☐Fall Risk
☐Assistance in/out of bed
☐Adjustable bed
☐Incontinence
☐Other: _____

ORDERS

Rev 01/02/2026