**COASTAL DIAGNOSTIC TESTING GROUP, Inc**
1957Thompson Rd Ste G, Coos Bay OR 97420
PHONE: (541) 756-7710 FAX: (541) 756-7699

Patient Name: _____
(PLEASE PRINT) LAST FIRST MIDDLE INITIAL

Home Phone: _____ Cell Phone: _____ DOB: _____

Address: _____

City _____ State: _____ ZIP Code: _____

Diagnosis: _____ ICD-10 Code: _____, _____

Insurance: _____ Allergies: _____

**ELECTROENCEPHALOGRAM**

☐ EEG (6 years and older only) special instructions: _____
_____

**POLYSOMNOGRAPHY (please choose only one)**

☐ PSG ☐ At Home ☐ At The Facility ☐ At The Laboratory

☐ CPAP☐ At Home ☐ At The Facility ☐ At The Laboratory

☐Pap Nap (Assist in pap acclimation)
☐ Overnight Pulse Oximetry
☐ Home Sleep Study ONLY, ☐ At Home ☐ At The Facility ☐ At The Laboratory

***Sleep Laboratory requirements: History and physical with sleep history, Overnight oximetry if available, patient demographics and insurance prior authorization, previous sleep study records if applicable.***

***If the patient's insurance requires Overnight Pulse Oximetry or Home Sleep Study in order to obtain prior authorization for PSG or Split Night studies, one will be performed without the need of a separate medical request.**

**Physician Signature:** _____ **Date:** _____

Physician: _____ NPI: _____

Phone: _____ FAX: _____

**Please fax forms to: Coastal Diagnostic Testing Group, Inc Fax: (541) 756-7699**

The Joint Commission requires that all orders be FAXED to the Coastal Diagnostic Testing Group, Inc at 541-756-7699 include a complete list of allergies.