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REFERRAL FORM

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____
Insurance (primary): _____ ID: _____
Insurance (secondary): _____ ID: _____

We do not accept any HMOs or Medi-Cal at this time.

- Service requested:**
- Consultation with our sleep specialist
 - Diagnostic Polysomnogram (PSG) – CPT code: 95810
 - Titration Polysomnogram (PSG) – CPT code: 95811
 - Multiple Sleep Latency Test (MSLT) – CPT code: 95805
 - Maintenance of Wakefulness Test (MWT) – CPT code: 95805
 - Split-night Polysomnogram (PSG) – CPT code: 95811
- (Patients must meet certain criteria during diagnostic portion of study in order to proceed to therapy that same night.)

Reason for Request:

- | | |
|---|--|
| <input type="checkbox"/> Snoring, apneas, abnormal nocturnal breathing | <input type="checkbox"/> Hypertension, CHF |
| <input type="checkbox"/> Obstructive sleep apnea (OSA) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) | <input type="checkbox"/> Periodic limb movement, RLS |
| <input type="checkbox"/> Sleepiness/Narcolepsy/Hypersomnolence/Parasomnia | <input type="checkbox"/> Coronary artery disease (CAD) |
| <input type="checkbox"/> Other: _____ | |

Notes: _____

Is there a specific DME you would like us to use for your patient? _____

Requesting physician: _____ Phone: _____
NPI #: _____ FAX: _____

Specialty: Cardiology Pulmonary Neurology ENT
 Family Practice Internal Medicine Other: _____

Signature: _____ Date: _____

***Please attach patient's history and physical, list of medications, and copy of insurance card.
Thank you in advance for your request.***