



Sleep Disorders  
Neuroscience

Group NPI # 1104458462  
Individual ID # 1427091727  
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**Please fax to (866) 984-4064**

## PHYSICIAN DIRECT REFERRAL FORM FOR SLEEP DISORDERS

PATIENT INFORMATION		
Name:	Gender <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Home Address:	Phone:	
Insurance:	Policy Number:	
Emergency Contact:	Phone:	
SERVICE REQUESTED		
<input type="checkbox"/> Sleep Medicine Consultation (95810/95811)	<input type="checkbox"/> Sleep Testing Only (95810/95811)	<input type="checkbox"/> Home Sleep Apnea Testing (HSAT) (95800)
<input type="checkbox"/> CPAP/Bilevel Titration Study (95811)	<input type="checkbox"/> Maintenance of Wakefulness Test (MWT) (95805)	<input type="checkbox"/> Multiple Sleep Latency Test (MSLT) (95805)
REASON FOR TESTING		
<input type="checkbox"/> Sleep Apnea, suspected (G47.30)	<input type="checkbox"/> Narcolepsy with Cataplexy (G47.411)	<input type="checkbox"/> Primary Hypersomnolence (F51.11)
<input type="checkbox"/> Obstructive Sleep Apnea, previously diagnosed (G47.33)	<input type="checkbox"/> Narcolepsy without Cataplexy (G47.419)	<input type="checkbox"/> REM Behavior Disorder (G47.52)
<input type="checkbox"/> Central Sleep Apnea, primary (G47.31)	<input type="checkbox"/> Insomnia, unspecified (G47.00)	<input type="checkbox"/> Snoring (R06.83)
<input type="checkbox"/> Restless Legs Syndrome (G25.81)	<input type="checkbox"/> Insomnia (F51.01)	<input type="checkbox"/> Seizures, unspecified (G40.89)
<input type="checkbox"/> Periodic Limb Movement Disorder (G47.61)	<input type="checkbox"/> Parasomnias, unspecified (G47.50)	<input type="checkbox"/> Other _____
SLEEP RELATED COMPLAINTS		
<input type="checkbox"/> Snoring	<input type="checkbox"/> Difficulty Initiating and Maintaining Sleep	<input type="checkbox"/> Obesity
<input type="checkbox"/> Witnessed Apnea	<input type="checkbox"/> Frequent Nocturnal Arousals	<input type="checkbox"/> OSA associated medical problems
<input type="checkbox"/> Excessive Sleepiness	<input type="checkbox"/> Restless leg sensations or kicking	<input type="checkbox"/> Preoperative screening for OSA
<input type="checkbox"/> Daytime Fatigue	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____
Please fax this form to <b>(866) 984-4064</b> prior to scheduling the patient's sleep study and include: <ul style="list-style-type: none"> <li><input type="checkbox"/> Written order for the Sleep Apnea Testing with appropriate indications</li> <li><input type="checkbox"/> Patient demographics, history, and most recent physical (include height, weight, BMI, and neck circumference)</li> <li><input type="checkbox"/> Sleep history, including the Epworth Scale and the Stop Bang Questionnaire</li> <li><input type="checkbox"/> Current list of medications and allergies</li> <li><input type="checkbox"/> Copies of insurance or Medicare/Medicaid cards</li> <li><input type="checkbox"/> Prior authorization number and copy of approval letter from insurance provider</li> </ul>		
Ordering Physician:	Specialty:	NPI:
Office Phone:	Office Fax:	Email:
Physician Signature:	Date:	