



## SLEEP STUDY REFERRAL FORM

### PATIENT INFORMATION:

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
 CITY/ST/ZIP: \_\_\_\_\_ SOCIAL SEC. # \_\_\_\_\_ DOB: \_\_\_\_\_  
 HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ OTHER# \_\_\_\_\_  
 HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

### INSURANCE INFORMATION:

INSURED NAME: \_\_\_\_\_ INSURED SS#: \_\_\_\_\_ INSURED DOB: \_\_\_\_\_  
 INS. CO. \_\_\_\_\_ I.D. # \_\_\_\_\_ GROUP # \_\_\_\_\_  
 INS. PHONE: \_\_\_\_\_

### PHYSICIAN INFORMATION:

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
 CITY/ST/ZIP: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_  
 PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ SEND REPORT TO ABOVE: YES NO  
 IF NO, SEND TO ADDRESS/FAX: \_\_\_\_\_

### REFERRING DIAGNOSIS:

\_\_\_\_\_ Apnea 327.23 \_\_\_\_\_ Unexplained Drowsiness 780.54 \_\_\_\_\_ Insomnia 780.52  
 \_\_\_\_\_ Narcolepsy 347.00 \_\_\_\_\_ Restless Legs Syndrome 333.99 \_\_\_\_\_ Periodic Limb Movement 327.51  
 \_\_\_\_\_ Unspecified Sleep Disturbance 780.50 \_\_\_\_\_ OTHER: \_\_\_\_\_

### INDICATIONS:

\_\_\_\_\_ Witnessed Apnea \_\_\_\_\_ Daytime Fatigue \_\_\_\_\_ Restless Sleep \_\_\_\_\_ Obesity  
 \_\_\_\_\_ Frequent Napping \_\_\_\_\_ Poor Memory \_\_\_\_\_ Irritability \_\_\_\_\_ Snoring  
 \_\_\_\_\_ Morning Headaches \_\_\_\_\_ OTHER: \_\_\_\_\_

### MEDICAL HISTORY:

\_\_\_\_\_ Asthma \_\_\_\_\_ Hypertension \_\_\_\_\_ Large tonsils \_\_\_\_\_ Allergies  
 \_\_\_\_\_ Emphysema \_\_\_\_\_ Nasal obstruction \_\_\_\_\_ Enlarged tongue \_\_\_\_\_ Obesity  
 \_\_\_\_\_ Seizures \_\_\_\_\_ Nasal polyps \_\_\_\_\_ Small pharyngeal inlet \_\_\_\_\_ Diabetes  
 \_\_\_\_\_ Deviated septum \_\_\_\_\_ Cardiac problems \_\_\_\_\_ Other: \_\_\_\_\_

### STUDY REQUESTED:

\_\_\_\_\_ Diagnostic Sleep Study – Polysomnogram (PSG) CPT-95810  
 \_\_\_\_\_ Titration with Nasal CPAP or BIPAP (circled which is preferred) CPT-95811  
 \_\_\_\_\_ PSG with Multiple Sleep Latency Test (MSLT) or Maintenance of Wakefulness Test CPT-95810 & 95805  
 \_\_\_\_\_ Split Night Study (NPSG/CPAP)  
 \_\_\_\_\_ FULL SERVICE - PSG, If Positive (AHI>5) Follow with Titration & CPAP Placement for Home Use

### SPECIAL INSTRUCTIONS / NEEDS:

Does Patient Have a trach? Yes No If yes, do you wish trach OPEN or CLOSED ?  
 Is Patient on Supplemental Oxygen? Yes No If yes, do you wish O2 during the test? Yes \_\_\_ L/min No

I AUTHORIZE SSA TO PERFORM SLEEP STUDIES ON ABOVE PATIENT ACCORDING TO THEIR PROTOCOLS, INCLUDING URGENT INITIATION OF O2 & CPAP.

PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

