iSLEEP PROGRAM

Referral Form

www.iSleepProgram.com

Fax # (888) 929-7537
Alt. Fax # (212) 234-3012
Tel # (888) 929-7533

☐ 147 W.116th St. New York, NY 10026

☐ 800 Second Ave. 9th Floor New York, NY 10017

☐ 775 E. 87th St. Brooklyn, NY 11236

☐ 1200 Waters Place Suite 104 Bronx, NY 10461

Patient Information **Please attach clinical notes*

Name: _____

Phone #: _____

Mobile Phone #: _____

Email Address: _____

Address: _____

City: _____ State: ____ Zip: _____

D.O.B. : _____ Gender: ☐ Female ☐ Male

Height: _____ Weight: _____

Co-Morbidities **Please attach clinical notes*

- ☐ Hypertension
- ☐ Cardiac Arrhythmia
- ☐ Seizures
- ☐ Leg Movement
- ☐ Congestive Heart Failure
- ☐ COPD (Chronic Lung Disease)
- ☐ Obesity-Hypoventilation Syndrome
- ☐ Diabetes
- ☐ Neuromuscular Weakness
- ☐ Cognitive Impairment
- ☐ Stroke (<6 Months)

Referred for Evaluation of (updated with ICD10 codes)

- ☐ Sleep Apnea G47.33
- ☐ Hypersomnia with Sleep Apnea G47.30
- ☐ Insomnia G47.00
- ☐ Restless Legs (RLS/PLMD) G47.81
- ☐ Narcolepsy G47.419
- ☐ Other _____

Type of Service Requested

- ☐ Sleep Test at the Sleep Lab
  - ☐ Nocturnal Polysomnogram (NPSG) 95810
  - ☐ Nasal CPAP Titration Study 95811
  - ☐ Split Night Study (NPSG/CPAP)
  - ☐ Multiple Sleep Latency Test (MSLT) 95805
  - ☐ Maintenance of Wakefulness Test (MWT) 95805
  - ☐ CPAP Pap Nap Test 95807
- ☐ Special Instructions _____
- ☐ Ambulatory-Home Sleep Test for evaluation of obstructive sleep apnea (OSA)
- ☐ Consultation with a Sleep Specialist
- ☐ Consultation with Pulmonologist

Chief Complaints/Clinical Information*

** (most insurance companies require at least two (2) symptoms)*

- ☐ Disruptive snoring
- ☐ Disturbed or restless sleep
- ☐ Non-Restorative Sleep
- ☐ Depression
- ☐ Excessive daytime sleepiness
- ☐ Witnessed Apnea Events during sleep
- ☐ Frequent unexpected arousals from sleep
- ☐ Gasping during sleep
- ☐ Choking during sleep
- ☐ Irritability/Moodiness
- ☐ Morning Headaches

Insurance Information

Primary Insurance: _____ Primary Care Physician: _____

ID/Cert/Policy #: _____ Primary Physician Contact #: _____

Referring Physician Information

Physician: _____ Signature: _____

Specialty: _____ NPI #: _____

Phone #: _____ Fax #: _____

Email Address: _____ Date: _____