Phone: (808) 443-2626
Fax: (808) 769-5061

How to request a sleep study for your patients:

1. Please confirm with your patient's insurance provider if prior authorization is needed for the study you are requesting. If it is required, please indicate the authorization number on the referral form.
2. Complete the referral form IN FULL, sign and return by fax along with your most recent office visit note to 808.769.5061.
3. Please include patient emails on the referral form when available, as patient information packets are delivered via email.
4. The Mango Sleep Center will contact your patient to schedule an appointment when completed referral form, office visit note and prior authorization have been submitted.
5. Data collected during the sleep study will be scored by certified scoring technicians, and then interpreted by Dr. John Dawson, our Medical Director. This process can take up to 3 weeks to complete. When results have been scored and interpreted, they will be faxed to your office right away. Please schedule your patient for a follow up appointment at your office to discuss the results and determine a course of treatment if applicable.

Thank you for your referral!

SLEEP STUDY REFERRAL FORM

Please complete **ALL** sections, then fax to 808-769-5061 with most recent office visit note

PATIENT INFORMATION:

Name: ____ Date of Birth: _____/_____/_____

Address: ____

Home Phone: ______________________________ Cell or other contact Phone: ____________

E-Mail Address: ____

INSURANCE INFORMATION: **PLEASE CHECK WITH INSURANCE CARRIER TO OBTAIN PRIOR AUTHORIZATION IF APPLICABLE.**

Insurance Carrier: _______________________ Member #: ______________ Auth. #: __________

Responsible party name: _________________________ Responsible party Date of Birth: _____/_____/_____

REFERRING PHYSICIAN: _________________ Specialty: ___________ Contact person: __________

Phone: ______________________________ Fax: ______________________________

TYPE OF SERVICE REQUESTED: **PLEASE CHECK ONE.**

1. _____ **Baseline** Polysomnography (Diagnostic overnight sleep test in lab. NO Titration). CPT 95810
2. _____ **CPAP Titration Only** (Continuous Positive Airway Titration for pts. with current/existing sleep data on file). CPT 95811
3. _____ **Split Night** Combined Diagnostic overnight sleep test & CPAP Titration. (Split at _____ AHI per Dr.) CPT 95811
4. _____ **MLST/MWT** Multiple Sleep Latency Test/Maintenance of Wakefulness Test (Daytime Nap Study) CPT 95805

SUSPECTED SLEEP DIAGNOSIS: **PLEASE INDICATE**: Obstructive Sleep Apnea Other: ______________________

Duration of Symptoms: __________ Medical Hx: ______________________________

PLEASE COMPLETE:

Ambulatory Patient? Yes No Patient in a wheelchair? Yes No Able to get out of bed and to bathroom on own? Yes No

Patient on O2: Yes: _____L/min NO **CPAP at home**? Yes: _____cm H20 NO

Height: _________ Weight: _________ BMI: _________ BP: ______/______ PULSE: _________ MALE/FEMALE ADULT/CHILD

*<u>**Difficulty with current CPAP/BiPAP**</u>? Please note problems or symptoms

____

____

Circle Any or All that apply below to Patient's HX

APNEA OBSERVED	**OBESITY**	**HEADACHE**	**DECLINING SOCIAL FUNCTION**	**SLEEPWALKING**
SNORING	**RECENT WEIGHT GAIN**	**FATIGUE**	**ANXIETY**	**BRUXISM**
GASPING WHILE ASLEEP	**CARDIAC ARRYTHMIAS**	**EXCESSIVE DAYTIME SOMNOLENCE**	**DEPRESSION**	**CHILDREN 5 years and older: Snoring (is always abnormal) Failure to grow**
SMALL OROPHARYNX	**HYPERTENSION**	**IMPAIRED INTELLECTUAL FUNCTION**	**INSOMNIA**	
ENLARGED TONGUE	**HEART FAILURE**		**RESTLESS LEGS**	
ENLARGED TONSILS	**COPD**		**NIGHT TIME SEIZURES**	
	ASTHMA			

Referring physician's signature: ____

Reviewed by John M. Dawson, MD FAASM: ______________________________________