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** Video-Polysomnography (Diagnostic overnight sleep test. 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

CIRCLE ANY/ALL THAT APPLY:

Apnea Observed	Obesity	Difficulty with current CPAP/BiPAP	Restless Legs	Insomnia	**CHILDREN 5 years and older:**
Snoring	Recent weight gain: _____ lbs	Headache	Post stroke	Depression	Snoring (is always abnormal)
Gasping at night	Cardiac Arrhythmias	Fatigue	Narcolepsy/Cataplexy	Declining social functioning	Failure to grow
Small Oropharynx	Hypertension	Excessive daytime somnolence	Sleepwalking	Grinding teeth	ADHD
Enlarged tonsils	Heart failure	Impaired intellectual functioning	Unusual or violent nocturnal movement	Short/thick neck	
Enlarged tongue	Asthma	Anxiety	Night time seizures	COPD	

Referring physician's signature: ______________________________
Reviewed by John M. Dawson, MD FAASM: ______________________________