SLEEP CONSULTANTS, INC.

Comprehensive Care for People with Sleep Disorders
Diagnosis, Treatment, Follow-up, Education, Research

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SCHEDULING: OPTION 2 OR EXTENSION 2041
Email: Information@SleepConsultants.com
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Sleep Study Referral Form

Thank you for referring your patient for a sleep study evaluation. In order to expedite patient acceptance and scheduling, we ask that this completed ***order form, most recent office visit notes and the patient's insurance/contact information*** *be faxed to* ***817-394-6282****. For more information, please call the office. We appreciate your patience and cooperation!*

Choose study:

- ☐ **Evaluate and treat** (CPT 95810 and 95811) Polysomnogram with second night CPAP Titration if clinically indicated.
- ☐ Home Sleep Testing (CPT 95806/G3099) For patients who do not have cardiac or pulmonary disease.
- ☐ PSG Only (CPT 95810) In-lab overnight polysomnogram for diagnostic purposes.
- ☐ CPAP Titration Only (CPT 95811) Must send copy of recent polysomnogram for sleep clinic file.
- ☐ Split Night Study (CPT 95811) If patient meets AASM criteria for split study.
- ☐ Auto Servo-Ventilation for Central Sleep Apnea (CPT 95811)
- ☐ Multiple Sleep Latency Test (MSLT) (CPT 95805)
- ☐ Maintenance of Wakefulness Test (MWT) (CPT 95805)

Check the suspected or confirmed diagnosis (check ALL that may be present):

- ☐ Obstructive sleep apnea (G47.33)
- ☐ Hypersomnia (excessive daytime sleepiness) (G47.10)
- ☐ Loud/disruptive snoring (R06.83)
- ☐ Hypertension (I10)
- ☐ Depression (F33.1)
- ☐ Fatigue (R53.83)
- ☐ Central sleep apnea (G47.31)
- ☐ Narcolepsy: ☐ with cataplexy (G47.411) ☐ without cataplexy (G41.419)
- ☐ Parasomnias, organic unspecified (G47.50)
- ☐ Periodic limb movement disorder (G25.81)
- ☐ Insomnia or difficulty maintaining sleep (G47.0)
- ☐ Other: _____

Please include the following with this order:

1. *Last physician note that includes patient's sleep symptoms and past medical history.*
2. *Patient demographics.*
3. *Insurance information.*

_____(____)_____-_____
Patient Name **DOB** **Best Contact Phone #**

_____
Ordering Provider **Office Contact/Nurse Name**

_____
Ordering Provider Signature **Date**

FOR OFFICE USE ONLY
RECEIVED BY:
DATE PATIENT WAS SPOKEN TO DIRECTLY BY STAFF:
DATE STUDY/REFERRAL SCHEDULED:
MEDICAL DIRECTOR APPROVAL: