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REFERRAL FORM

PATIENT INFORMATION:

Patient Name: _____ Order Date: _____
 Identifier/Record: _____ Ordering Physician: _____
 Home Phone #: _____ Work Phone #: _____
 Insurance: _____
 Authorization #: _____

Arrival Time (circle one) **8:00PM** **9:00PM** Scanned Date: _____
 Rescheduled Scanned Date: _____

Internal use only: (date and initials)

No Show: _____
 Reschedule Date: _____
 Info Sheet to Pt. _____ Date Scored: _____
 Confirmation Call Day of Study: _____ Scoring Tech: _____
 Reports Visit/Call Date: _____ Recording Tech: _____

Diagnosis for Test Below: Obstructive Sleep Apnea G47.33; Hypersomnia NOS G47.10; Hypersomnia due to medical condition G47.14; Idiopathic Hypersomnia w/long sleep time G47.11; Idiopathic Hypersomnia without long sleep time G47.12; Narcolepsy w/cataplexy 347.00 (G47.411); Narcolepsy w/o Cataplexy 347.01 (G47-419); Insomnia NOS 780.52 (G47.00); Obesity Hypoventilation syndrome E66.2; Sleep related non-obstructive Alveolar Hypoventilation G47.34; REM sleep behavior disorder 327.42(G47.52)

SLEEP CENTER TESTING PROTOCOL-ORDER:

- Diagnostic Polysomnogram** (Comprehensive sleep study / "PSG") (CPT 95810)
- Split Night Polysomnogram** (Comprehensive sleep study + CPAP titration or other therapy) (CPT 95811)
(For therapy other than Cpap please add details in "special instructions" section below)
*Split after AHI of _____ . **A REM period is or is not required before splitting.***
- REM Preferred 2 AM Split**
- CPAP Titration Polysomnogram** (Full night of CPAP at a fixed or titrated level) (CPT 95811)
- MSLT** (Multiple Sleep Latency Test following overnight PSG) (CPT 95805)
- MWT** (Maintenance of Wakefulness Test following overnight PSG) (CPT 95805)
- Limited Polysomnogram** (Cardio-respiratory recording w/o EEG)
- IN-HOME SLEEP TEST** Overnight sleep test-pick up and return from our office. (CPT 95806)

ORDERING OPTIONS:

- Lights out preferred: _____ AM/PM Lights on preferred: _____ AM/PM
- Oxygen via: nasal cannula at _____ L/min; Entrained into CPAP/Bilevel mask at _____ L/min;
 Via mask (plain; venturi) at FIO2 _____ or _____ L/min.
- Do not use supplemental oxygen unless additional order is given.
- Hypnotic needed: (Rx to patient or patient to bring meds to lab)
- Do not take _____
- Patient to take all medications: _____

Relevant Medications: _____

Problems:
 Diabetes Mellitus: Y / N Atrial Fib (or PAF): Y / N Pacemaker: Y / N

SPECIAL INSTRUCTIONS: (please add **specific** changes to protocol or montage here)

Signature: _____ Date: _____