

**Accredited by the American Academy of Sleep Medicine**

**REFERRAL FOR SLEEP DIAGNOSTIC TESTING/CONSULTATION**

|                            |        |      |                    |
|----------------------------|--------|------|--------------------|
| <b>PATIENT INFORMATION</b> |        |      | Daytime Phone: ( ) |
| Name:                      |        |      | Evening Phone: ( ) |
| Address:                   |        |      | Mobile Phone: ( )  |
| City:                      | State: | Zip: | Date of Birth:     |

**SERVICES REQUESTED:**

(Please send copies of History and Physical if not requesting a Consultation with the Sleep Specialist)

- Consultation with Sleep Specialist
- Patient follow-up by Sleep Specialist (w/o initial consultation)
- Diagnostic Polysomnogram --sleep study (CPT code 95810)
- Polysomnogram with CPAP titration (CPT code 95811)
- Split night PSG (4 hour diagnostic followed by CPAP titration; must meet Criteria, AHI >40)
- Multiple Sleep Latency Test; MSLT (CPT codes 95805) Performed following PSG to evaluate sleepiness/Narcolepsy
- Home Sleep Study (G0399) no sleep staging, unattended (may not be covered under all health Plans)

**INDICATIONS FOR STUDY: ICD-9**

- |  |   |
|--|---|
| <input type="checkbox"/> 327.23 Obstructive Sleep Apnea                    | <input type="checkbox"/> 333.99 Restless Legs Syndrome          |
| <input type="checkbox"/> 327.25 Sleep Related Hypoventilation/Hypoxemia    | <input type="checkbox"/> 327.51 Periodic Limb Movement Disorder |
| <input type="checkbox"/> 327.21 Primary Central Sleep Apnea                | <input type="checkbox"/> 3273.33 Irregular Sleep Wake type      |
| <input type="checkbox"/> 347.0 Narcolepsy                                  | <input type="checkbox"/> 327.42 REM Sleep Behavior Disorder     |
| <input type="checkbox"/> 327.14 Hypersomnia due to Medical Condition (OSA) | <input type="checkbox"/> 250.0 Diabetes                         |
| <input type="checkbox"/> 327.01 Insomnia due to Medical Condition          | <input type="checkbox"/> 401.9 Hypertension                     |
| <input type="checkbox"/> 491.21 COPD                                       |   |

**COMMENTS, OTHER INFORMATION OR ORDERS :**

**PHYSICIAN INFORMATION:**

|          |                   |
|----------|-------------------|
| Name:    | Office Phone: ( ) |
| Address: | Office Fax : ( )  |
|          | Contact:          |

**MD Signature:**

**Based on the patient's history and diagnosis, I have requested the indicated test(s) be performed and certify that this testing is medically necessary.**