## Sleep Unlimited, INC.

Cordova, TN phone: 901-737-9196

fax: 901-432-6230

## REFERRAL FORM (CERTIFICATE OF MEDICAL NECESSITY)

**Note:** Please submit a copy of patients' current demographic sheet along with copy of Insurance Card or Insurance Information. Thank you for your referral. We will schedule your patient and notify you of date of study as soon as possible.

		·
PATIENTS NAME:	DOE	3:
M F Height:	Weight:SSN	
PHONE:INSURANCE:		
<b>HEENT exam</b> : (or last pl	hysician notes on chart with physical in	nformation)
( ) WNL ( ) TMJ ( ) Sinus Disease	. ,	( ) Elongated Uvula ( ) Tonsils size ( ) 1+ ( ) 2+ ( ) 3+ ( ) 4+
( ) Sleep Paralysis	<ul> <li>( ) Excessive daytime sleepiness</li> <li>( ) Awakening gasping for breath</li> <li>( ) Non-restorative sleep</li> <li>( ) Leg restlessness or jerks</li> </ul>	<ul><li>( ) Obesity</li><li>( ) Hypertension</li></ul>
TEST(s) REQUESTED:		
95805	omnography greater than six hours (all leep Latency Tests (MSLTs) ce of Wakefulness Tests (MWTs) requaP/BiLevel Titration Study ollow-up (PSG) ow-up Study apnea screening (one night) cal Consult OR Clinic appointment with	ired for DOT license
DME – pro	ovided by	
Indicate any other medica	l problems or special concerns:	
patient may require two sleep studies a	medically necessary sleep study or evaluation for the reaund will be scheduled for the second study according to wr be performed to titrate CPAP to the appropriate pressure.	ritten protocol which states that if the RDI for the
Referring Physician:	I	Date:

## **Patient Information Sheet**

Patient Name:		Today's Date:		
		Date of Birth:		
Home Address:				
Email Address:				
Patients Employer:				
Occupation:				
Referring Physician:				
Chief Complaint:				
		ing (home) Phone:		
Cell Phone:				
Spouse:	 Emi	ployer:		
	Phone Number:			
	110			
May we leave a message for	your on your home o	or work number?		
		whom may we discuss your scheduling,		
results, and treatment?	<b>,</b> ,	<b>,</b> ,		
	Phone Number:			
		<del> </del>		
Primary Insurance Information				
Insurance Company				
Address:				
	Contact:			
Primary Insured:	Insured's Date of Birth:			
ID#	Group/Policy#_	Deductible:		
Secondary Insurance Information				
Insurance Company				
Address:				
Telephone:				
	Insured's Date of Birth:			
		Deductible:		

Ame 3/5/05