

## 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: \_\_\_\_\_ DOB: \_\_\_\_\_

M  F  Height: \_\_\_\_\_ Weight: \_\_\_\_\_ SSN# \_\_\_\_\_

PHONE: \_\_\_\_\_ INSURANCE: \_\_\_\_\_

**HEENT exam:** (or last physician notes on chart with physical information)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> WNL           | <input type="checkbox"/> Deviated Septum   | <input type="checkbox"/> Elongated Uvula  |
| <input type="checkbox"/> TMJ           | <input type="checkbox"/> Nasal Obstruction | <input type="checkbox"/> Tonsils size   |
| <input type="checkbox"/> Sinus Disease | <input type="checkbox"/> Mouth Breathing   | <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ |

### PRESENTING SYMPTOMS:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Loud snoring      | <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Fatigue           |
| <input type="checkbox"/> Witnessed Apnea   | <input type="checkbox"/> Awakening gasping for breath | <input type="checkbox"/> Obesity           |
| <input type="checkbox"/> Sleep Paralysis   | <input type="checkbox"/> Non-restorative sleep        | <input type="checkbox"/> Hypertension      |
| <input type="checkbox"/> Morning Headaches | <input type="checkbox"/> Leg restlessness or jerks    | <input type="checkbox"/> Morning Dry Mouth |

### TEST(s) REQUESTED:

- 95810  Full Polysomnography greater than six hours (all night study)
- 95805  Multiple Sleep Latency Tests (MSLTs)
- 95805  Maintenance of Wakefulness Tests (MWTs) required for DOT license
- 95811  Nasal CPAP/BiLevel Titration Study
- 95810  Surgical Follow-up (PSG)
- 95811  CPAP follow-up Study
- 95806  In – Home apnea screening (one night)
- Clinic appointment with Sleep Physician
  
- DME – provided by \_\_\_\_\_

Indicate any other medical problems or special concerns: \_\_\_\_\_

I have referred the above patient for a medically necessary sleep study or evaluation for the reason indicated on this form. I am aware that this patient may require two sleep studies and will be scheduled for the second study according to written protocol which states that if the RDI for the PSG is >5, the second study will then be performed to titrate CPAP to the appropriate pressure. If daytime sleepiness is present, a MSLT study may be performed per written protocol.

Referring Physician: \_\_\_\_\_ Date: \_\_\_\_\_

## Patient Information Sheet

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

SS #: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Email Address: \_\_\_\_\_

Patients Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Day (work) Phone: \_\_\_\_\_ Evening (home) Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

May we leave a message for your on your home or work number? \_\_\_\_\_

In the event that we are unable to reach you, with whom may we discuss your scheduling, results, and treatment?

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Primary Insurance Information

Insurance Company \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Contact: \_\_\_\_\_

Primary Insured: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

ID# \_\_\_\_\_ Group/Policy# \_\_\_\_\_ Deductible: \_\_\_\_\_

### Secondary Insurance Information

Insurance Company \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Contact: \_\_\_\_\_

Primary Insured: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

ID# \_\_\_\_\_ Group/Policy# \_\_\_\_\_ Deductible: \_\_\_\_\_