

Sleep Unlimited, INC.

fax: 901-837-8873

Munford, TN

phone: 901-837-8868

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)
- Neurological Consult OR 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: _____