

# FAMILY SLEEP DIAGNOSTICS

## PHYSICIAN SLEEP STUDY REFERRAL FORM

*Multiple locations providing comprehensive sleep services throughout the DFW Metroplex*

Scheduling: 972-714-0011

**FAX: 800-816-1477**

Toll Free: 888-714-0011

Patient: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Best Phone # : \_\_\_\_\_

### STEP 1- Choose a sleep study service

- |  |  |
|--|--|
| <input type="checkbox"/> <b>Evaluate and Treat</b> (CPT 95810 & 95811) | Polysomnogram, with 2nd night CPAP Titration, if indicated.                            |
| <input type="checkbox"/> Sleep Specialist Consult                      | Evaluation of patient's sleep complaints with f/u recommendations.                     |
| <input type="checkbox"/> PSG Only (CPT 95810)                          | 1st Night Diagnostic Study <b>only</b> .   |
| <input type="checkbox"/> CPAP Only (CPT 95811)                         | 2nd Night Titration Study <b>only</b> ( <i>must have copy of recent PSG on file</i> ). |
| <input type="checkbox"/> Bi-Level Titration (CPT 95811)                | Patient failed CPAP and requires further titration efforts.                            |
| <input type="checkbox"/> AutoSV – Central Apneas (CPT 95811)           | Confirmed Central Sleep Apnea, requires advanced titration with ASV.                   |
| <input type="checkbox"/> Split Night Study (CPT 95811)                 | Initial Diagnostic period followed by CPAP initiation for RDI > 40.                    |
| <input type="checkbox"/> Specialized Split Night                       | Same night PSG followed by CPAP initiation for RDI > 20                                |
| <input type="checkbox"/> Mandatory Split Night                         | Same night PSG followed by CPAP initiation, no RDI requirements                        |
| <input type="checkbox"/> MSLT (CPT 95805)                              | Daytime nap study for EDS ( <i>Mandatory PSG performed preceding night</i> ).          |
| <input type="checkbox"/> MWT (CPT 95805)                               | Daytime nap study to verify wakefulness.   |
| <input type="checkbox"/> Oral Appliance Evaluation                     | Dental consult & evaluation for oral appliance for OSA treatment.                      |

### STEP 2- Choose the suspected or confirmed patient diagnosis (*check all that apply*)

- |  |   |
|--|---|
| <input type="checkbox"/> 327.23 <b>Obstructive Sleep Apnea</b>                                 | <input type="checkbox"/> 327.40-49 Organic Parasomnias, unspecified   |
| <input type="checkbox"/> 327.10-19 Hypersomnia (inc. Excessive Daytime Sleepiness)             | <input type="checkbox"/> 347.00-01 Narcolepsy – daytime sleep attacks |
| <input type="checkbox"/> 327.21 Primary Central Sleep Apnea                                    | <input type="checkbox"/> 786.09 Loud or disruptive snoring            |
| <input type="checkbox"/> 327.30-39 Circadian rhythm sleep disorders (inc. Shift Work Disorder) | <input type="checkbox"/> 278.00-01 Obesity/Morbid Obesity             |
| <input type="checkbox"/> 327.51 Periodic limb movement disorder                                | <input type="checkbox"/> 780.79 Fatigue or Malaise                    |
| <input type="checkbox"/> 307.41-48 Difficulty initiating or maintaining sleep                  | <input type="checkbox"/> 346.0-9 Migraine                             |
| <input type="checkbox"/> 327.8/780.57 Unspecified Sleep Disturbance/Apnea                      | <input type="checkbox"/> Other: _____                                 |

### STEP 3- Attach the required documentation

- Patient Demographics** (*to include address, DOB, social security number, current phone*)
- Insurance Information** (*if faxing insurance card, please enlarge and send front and back*)

*Mandatory for all Medicare patients or patients requiring precertification):*

- Clinical Information** (*Sleep evaluation documentation and/or copy of physician visit notes detailing sleep issues*)

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

Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Completed by: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Physician Fax: \_\_\_\_\_

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

Special Instructions/Remarks