



Referral Information and Order Form
PLEASE FAX TO: 480-603-0620

Patient

Name:		Date:	
SS#:	DOB:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address:			
City:		Zip:	
Home Phone:	Work #:	Cell#	
Insurance:	ID:	Group:	
Insurance:	ID:	Group:	

Orders/Requests

SLEEP STUDIES

- Diagnostic Polysomnogram (95810):** Do *not* initiate CPAP.
- Split Night PSG (95811):** The study protocol requires 120 minutes of diagnostic sleep time to be recorded in addition to clinical criteria identifying significant OSA followed by ample time to titrate CPAP (≈ 4 hours).
- Continuous Positive Airway Pressure (CPAP) Titration Study (95811):** CPAP study is needed to determine the amount of air pressure required to treat OSA.
- Bi-Level Positive Airway Pressure (BiPAP) (95811):** BiPAP is needed for treatment of: { } Neuromuscular Disease; { } COPD; { } OSA
- AutoSV Titration Study (95811):** Requires the diagnosis from a previous sleep study of Complex Sleep Apnea
- Multiple Sleep Latency Test (MSLT) (95805):** PSG is **required** the night before to document sleep time. A two week sleep diary is also **required** to document sleep/habits from the previous nights.
- Maintenance Wakefulness Test (MWT) (95805):** PSG is **recommended** the night before to document sleep time. A two week sleep diary is **required** to document sleep/habits from the previous nights.

CONSULTATIONS (optional)

- Consultation with Sleep Specialist:**
 { } Pre-Study and subsequent Follow-up { } Follow-up only after sleep study
- Daytime Mask Fitting/CPAP Clinic:** Indicated for patients with mask intolerance. Experienced technical staff will fit the patient with a variety of nasal/full face mask interfaces to find the most comfortable device.

Initial Complaints/Reasons for Sleep Study

Diagnosis: _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Obstructive Sleep Apnea 327.23 | <input type="checkbox"/> Insomnia with Sleep Apnea, Unspecified 780.51 | <input type="checkbox"/> Narcolepsy, w/o Cataplexy 347.00 |
| <input type="checkbox"/> Idiopathic Non-obstructive Alveolar Hypoventilation 327.24 | <input type="checkbox"/> Hypersomnia with Sleep Apnea, Unspecified 780.53 | <input type="checkbox"/> Narcolepsy with Cataplexy 347.01 |
| <input type="checkbox"/> Periodic Limb Movement Disorder 327.51 | <input type="checkbox"/> Hypersomnia, Unspecified 780.54 | <input type="checkbox"/> Sleep related Movement Disorder, Unspecified 780.58 |
| <input type="checkbox"/> Epilepsy and Recurrent Seizures 245.80 | <input type="checkbox"/> Unspecified Sleep Apnea 780.57 | <input type="checkbox"/> Other Sleep Disturbances 780.59 |

Pertinent Medical History

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Witnessed Apnea | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> GERD | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Post UPPP | <input type="checkbox"/> S/P Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> HTN | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Daytime Sleepiness | <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Restless Leg Syndrome | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> COPD | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Nightmares |

To expedite scheduling, please fax this completed form along with history & physical and a copy of insurance card.

Office Contact: _____ Office Phone: _____
 Office Fax: _____

I authorize CSS to perform services on the above patient according to the clinical protocols approved by the Medical Director.

Physician Name: _____ **Physician Signature:** _____

Thank You For Your Referral !