

# FAMILY SLEEP DIAGNOSTICS

## SLEEP STUDY REFERRAL FORM

SCHEDULING: (972) 714 -0011

info@familysleepdiagnostics.com

TOLL FREE FAX: (800) 816 -1477

Preferred Lab Sleep Location:  Las Colinas  Plano  HEB MidCities  Mansfield/Arlington

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

**Required Attachments:**  Patient Demographics  Insurance Information  Sleep Evaluation Documentation

Is this a Medicare Patient?  No If "No", skip to the next section  Yes If "Yes", see below

If "Yes", it is mandatory to complete this section in full - OR - attach copy of sleep evaluation visit which details the same information

Epworth Score \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Neck Circumference \_\_\_\_\_

B/P \_\_\_\_\_ Primary Symptoms:  Snoring  Apnea  Excessive Daytime Sleepiness

Other: \_\_\_\_\_

I authorize the following Sleep Study to be performed at the Family Sleep Diagnostics facility (check one):

- Evaluate and Treat** (CPT 95810 & 95811) Polysomnogram, with 2nd night CPAP Titration, if indicated.
- PSG Only** (CPT 95810) 1st Night Diagnostic Study for Evaluation Only.
- CPAP Only** (CPT 95811) 2nd Night Titration following Diagnostic Study with DX of OSA/OSH.  
if patient had PSG/CPAP at another lab, please fax previous PSG/CPAP report(s)
- Bi-Level Titration** (CPT 95811) Patient failed CPAP and requires further titration efforts.
- AutoSV – Central Apneas** (CPT 95811) Confirmed Central Sleep Apnea, requires advanced titration with ASV.
- Split Night Study** (CPT 95811) Initial Diagnostic period followed by CPAP initiation for RDI >40.
- MSLT** (CPT 95805) Daytime nap study for EDS (Mandatory PSG performed preceding night).
- MWT** (CPT 95805) Daytime nap study to verify wakefulness.

The medical necessity for the Sleep Study is because the patient has the suspected diagnosis of or is exhibiting the following symptoms:

- |                                                                                                |                                                                       |
|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> 327.23 Obstructive Sleep Apnea                                        | <input type="checkbox"/> 327.44 Parasomnias                           |
| <input type="checkbox"/> 327.10-15 Hypersomnia (inc. Excessive Daytime Sleepiness)             | <input type="checkbox"/> 347.00-01 Narcolepsy – daytime sleep attacks |
| <input type="checkbox"/> 327.40-42 Nocturnal Awakenings / Arousals during sleep                | <input type="checkbox"/> 786.09 Loud or disruptive snoring            |
| <input type="checkbox"/> 327.31-39 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"/> 333.99 Restless legs just prior to, or while falling asleep           | <input type="checkbox"/> 346.0-9 Migraine                             |
| <input type="checkbox"/> 327.8 Unspecified Sleep Disturbance                                   | <input type="checkbox"/> Other: _____                                 |

Other : \_\_\_\_\_

Special Instructions / Needs: (O2, wheelchair, etc.) \_\_\_\_\_

Currently on CPAP:  Yes  No

Since When: \_\_\_\_\_

Pressure: \_\_\_\_\_

**Physician to Interpret results:**

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

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

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

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

City: \_\_\_\_\_

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

Fax Number: \_\_\_\_\_