FAMILY SLEEP DIAGNOSTICS

SAVING LIVES AND MARRIAGES

Phone: 972-714-0011 **familysleepdiagnostics.com**

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Sleep Study Referral Form

Patient Name: ______________________________ Date of Birth: ____________________

Phone Number: ________________________ Email: ______________________________

Height:__________ Weight:________ Please Attach: ☐ Demographics ☐ Insurance Info. ☐ Clinicals

Indications for Sleep Testing

☐ Obstructive Sleep Apnea G47.33	☐ Narcolepsy with Cataplexy G47.411
☐ Sleep Apnea, Unspecified G47.30	☐ Narcolepsy without Cataplexy G47.419
☐ Primary Central Sleep Apnea G47.31	☐ Excessive Daytime Sleepiness G47.10
☐ Insomnia with Sleep Apnea G47.30	☐ Hypersomnia, Unspecified G47.10
☐ Hypoventilation/Hypoxemia Conditions G47.90	☐ Periodic Limb Movement Disorder G47.61
☐ Sleep Wake Cycle Disruptions/Dysfunction G47.23	☐ Parasomnia, Unspecified G47.50

☐ REM Disorder Recurrent Sleep Paralysis Organic Sleep Movement Disorder G47.53

Type of Test Requested

Test	CPT
☐ **Evaluate, Diagnosis & Treat** Sleep Specialist to diagnose and manage patient's sleep disorder	
☐ **EVT** Diagnostics polysomnogram and 2nd night PAP Test, if indicated	95811/95810
☐ **PSG Only** 1st Night diagnostics study only	95810
☐ **Split Night Study** Single night study initiated as diagnostic study:	95811
❏ if AHI > 15/hr (unless otherwise specified), initiate PAP therapy	
❏ if AHI > 40/hr (unless otherwise specified), initiate PAP therapy	
❏ Mandatory, no AHI minimum ☐ If a second study is required to achieve PAP titration - please proceed	
☐ **HST** Home Sleep Test ☐ Home sleep test is acceptable, if carrier or patient will NOT approve in-lab setting	95806
☐ **MSLT/PSG** Diagnostics night study followed by a day study for suspected narcolepsy/ hypersomnolence	95810/95805
☐ **MWT** Drivers and pilot - diagnostics study to test ability to remain awake	95810/95805
☐ **Overnight Pulse Oximetry**	95805
☐ **Oral Appliance Therapy Study**	94762
☐ **Oral Appliance Therapy Consultation**	
☐ **Inspire Appliance Therapy Study**	
☐ **Inspire Appliance Therapy Consultation**	
☐ **Routine and 72 Hour Video EEG**	

☐ Loss of Time consciousness	☐ Memory Loss	☐ Forgetting recalling words	
☐ Aphasia	☐ Staring spells	☐ Involuntary Movement or jerking	
☐ Out of body sensations	☐ DeJa Vu sensations	☐ Syncope	☐ Concussions

Special Instructions (i.e. special split requirements):__________________________________

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Physician's Name (Printed): ____________________ Phone:________________________

Physician's Signature: ____________________ Fax:________________________