

REQUEST FOR SLEEP LAB SERVICES

Today's Date _____ Patient Name _____

Date of Birth _____ Day/Evening Patient Phone # _____

Address _____

Referring Doctor _____ Insurance _____

Referral Note: This does not replace referral forms required by most HMO/POS insurance plans. These plans may require a referral be processed prior to a test being performed. Please check with your individual plan guidelines.

REQUESTED TEST INFORMATION

Please check all that apply to assure proper ordering and billing:

1. Request Study:

- Diagnostic Sleep Study 95810
- Split Night Study with NCPAP if indicated 95811
- NCPAP Titration / Retitration 95811
- Oxygen Titration
- Nocturnal Oximetry 94762
- Multiple Sleep Latency Test or MWT (CPT 95805)
- Sleep Consultation with Physician
- Free Consultation with Technologist
- Testing w/oral appliance

2. Select Interpreting Physician:

- L.E. Alberti, MD, FCCP, ABSM
- J. Doud, MD, FCCP
- S. Kalra, MD, FCCP, ABSM
- A. Siddiqui, MD, FCCP
- S. Ahmed, MD, FCCP

3. Please document reason for testing and any special health concerns:

- 327.23 Obstructive Sleep Apnea Syndrome
- 327.51 Periodic Limb Movement Disorder
- 327.21 Central Sleep Apnea Syndrome
- 347 Narcolepsy
- 327.00 Insomnia
- 780.54 Hypersomnia
- 307.42-0 Psychophysiological Insomnia
- 327.42 REM Sleep Behavior Disorder
- 327.20 Sleep Apnea / Sleep Related Breathing Disorder, Unspecified
- 333.94 Restless Leg Syndrome
- Other _____

Physician Signature:

Date _____