American Sleep Centers
9439 Archibald Ave. Suite 105
Rancho Cucamonga, CA 91730

AMERICAN SLEEP CENTERS

Sleep Medicine Referral Form

Phone: (866) 987-1611 Fax: (909) 987-5510

PATIENT NAME:_____ **DOB:** _____ **SS#**_____
Last **First** **MI**
ADDRESS:_____**City:**_____**State:**_____**Zip:**_____

HOME:_____ **CELL:** _____ **CELL CARRIER:** _____**EMAIL:**_____

Height: _____ **Weight:** _____ **Neck Circumference:** _____ **Oxygen Use (Y/N):** _____ **Sex: (M/F):** _____

INSURANCE: □ **Medicare** □ **Work Comp** □**PPO** **Name of Insurance Company**_____
Policyholder ID#_____

Please attach patient's clinical history, medications, physician's notes, demographics, & insurance information

Referring Physician: _____ **NPI:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Email:** _____

SYMPTOMS & REASON FOR REFERRAL

☐ **Witness/Suspected Sleep Apnea**	☐ **Snoring**	☐ **Excessive Daytime Sleepiness**	☐ **Morning Headaches**
☐ **Hypertension**	☐ **Obesity** ☐ **Diabetes**	☐ **Cardiac Disease** **Type** _____	☐ **COPD**
☐ **Periodic Limb Movement Disorder**	☐ **Restless Leg Syndrome**	☐ **Narcolepsy**	☐ **Insomnia** ☐ **Parasomnia**

SLEEP DISORDERS DIAGNOSTIC SERVICES

☐ **Comprehensive Sleep Study/Evaluation:** by Board Certified/Eligible Sleep Specialist to determine and order appropriate testing procedure. **(CPT 95810, 95811, 99204, 99214, or 99215)**

☐ **PSG:** Full night in lab diagnostic polysomnography attended by a technologist. **(CPT 95810)**

☐ **Split PSG:** Full night in lab diagnostic polysomnography attended by a technologist with PAP, oxygen, or oral appliance titration. Please attach previous diagnostic sleep test. **(CPT 95811)**

☐ **Full PSG Titration:** Full night in lab polysomnography attended by a technologist with PAP, oxygen, or oral appliance titration. Please attach previous diagnostic sleep test. **(CPT 95811)**

☐ **MSLT/MWT:** Multiple Sleep Latency Test/Multiple Wakefulness Test used to rule out narcolepsy.
Note: If patient meets diagnostic and procedural protocol, PAP titration will be performed and MSLT cancelled.
(CPT 95805)

☐ **Home Sleep Test (HST):** If clinical criteria is met, diagnostic sleep test primarily to diagnose obstructive sleep apnea. **(CPT 95806 or 95800)**

☐ **Special Requests:** _____ **DME Preference:** _____

Physician Signature: _____ **Date:** _____ **Direct Referral:** _____