

NEUROLOGY & SLEEP MEDICINE

PATIENT INFORMATION			
Patient Name	Social Security #	DOB	Marital Status M S
Home Phone	Work Phone		
E-Mail Address	Fax Number		
Address	City, State, Zip		
REFERRING PHYSICIAN INFORMATION			
Referring Physician Name	Person Completing Referral for Consult		
Street Address	City, State, Zip		
Phone Number	Fax Number		
Specialty	UPIN # Required		
INSURANCE INFORMATION *(Please fax an enlarged copy of the front and back of the insurance card)*			
Insurance Company Name	Referral/Pre-Cert Number (If required)		
Policy Number	Benefits Phone Number		
Insured employer name	Group Number		
Name of Insured	Relation To Patient		
INDICATIONS (Please check/list identified symptoms and complaints)			
<input type="checkbox"/> Snoring <input type="checkbox"/> Apnea <input type="checkbox"/> Daytime Sleepiness <input type="checkbox"/> Insomnia <input type="checkbox"/> RLS/PLMS <input type="checkbox"/> Other(s)[Describe]			
REFERRAL OPTIONS (Please mark requested service(s) below)			
<input type="checkbox"/> CONSULT WITH PHYSICIAN, SLEEP STUDY & TREATMENT (CPT 99245)			
SLEEP STUDY ONLY - <u>WITHOUT</u> CONSULT <i>(check appropriate box below)</i>			
<u>YOU MUST FAX TO US:</u> 1). Recent office notes with clinical indications for disorder 2). History & physical.			
<u>Please order requested procedure(s) by checking the appropriate box below:</u>			
<input type="checkbox"/> Diagnostic Sleep Study (Polysomnogram) (CPT 95810) <small>(Urgent CPAP may be applied per established protocols)</small>		<input type="checkbox"/> Home Pulse Oximetry (CPT 94762)	
<input type="checkbox"/> Nasal CPAP Titration Sleep Study (CPT 95811) <small>(Previous diagnostic sleep study required)</small>		<input type="checkbox"/> Other:	
<input type="checkbox"/> Split Night Sleep Studies (CPT 95810 and 95811) <small>(Patient must meet established criteria)</small>			
<i>This form will serve as a prescription for the services you have ordered for your patient. If you have questions regarding these requirements, please contact our office at 505-887-5511</i>			
Thank You			
Signature of Ordering Physician:			Date: