

Phone: 303-407-1990



Fax: 303-407-5098

SLEEP TESTING REFERRAL FORM

PATIENT INFORMATION:

Last Name _____ First Name _____ DOB _____ SSN _____
 Address _____ City _____ Zip _____
 Phone (Home) _____ Phone (Work) _____ Sex _____ Email _____
 Insurance _____ ID# _____ Group # _____
 Subscriber _____ Employer _____

HISTORY & PHYSICAL: Check all that apply: Please include any pertinent sleep medical history from patient file (American Academy of Sleep Medicine guidelines)

Height _____ Weight _____

<input type="checkbox"/> Excessive Daytime Sleepiness	<input type="checkbox"/> Hypertension	<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Snoring	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression
<input type="checkbox"/> Witnessed Apnea/Choking	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Sleep Walking/Talking/Eating	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Deviated Septum	<input type="checkbox"/> Developmentally Disabled
<input type="checkbox"/> Sleep Paralysis	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Physically Disabled
<input type="checkbox"/> Insomnia	<input type="checkbox"/> DVT/PE		<input type="checkbox"/> Other _____

SUSPECTED SLEEP DISORDERS:

Obstructive Sleep Apnea (OSA) Narcolepsy Insomnia Periodic Limb Movements (PLM)
 Nocturnal Seizures Parasomnias (Sleepwalking, REM Behavior disorder) Other _____

THIS PATIENT IS BEING REFERRED FOR:

Split-Night Polysomnogram: Diagnostic sleep study and CPAP titration in one night; most common study ordered (95811)
 Diagnostic Polysomnography (PSG): All night diagnostic sleep study (95810)
 CPAP or BiLevel Titration: Full night of CPAP or BiLevel therapy for patients with confirmed sleep apnea (95811)
 Multiple Sleep Latency Test: Series of naps to measure excessive daytime sleepiness and rule out narcolepsy (Follows PSG) (95805)
 Consultation: Interview with sleep specialist

REFERRING PHYSICIAN INFORMATION:

Physician's Full Name (Please Print) _____
 Contact Person _____ Phone _____ Fax _____

SPECIAL INSTRUCTIONS: _____

PHYSICIAN'S SIGNATURE: _____ Date: _____

Please fax this information to AlphaSleep® Diagnostic Centers at 303-407-5098.
Visit our website at www.alphasleep.com