OBSTRUCTIVE SLEEP APNEA DIRECT REFERRAL FORM

FAX FORM TO:
Gaylord & Cheboygan: (231) 487-5759 **Petoskey:** (231) 439-0059 **Newberry:** (906) 293-1688

In-Center Sleep Studies and Home Testing

Clinical notes MUST reflect indications and medical necessity.

Patient

Last Name: ____________________ First Name: ____________________ DOB: ____________

Address: ______________________________ Phone: ____________________

Requesting Provider Information:

Provider Name: ____________________ Phone: ______________ Fax: ______________

Address: ____

Contact name: ____________________ Date of request: ______________

Clinical Information:

- ☐ **S** Snoring
- ☐ **T** Tired/Sleepy
- ☐ **O** Observed Apnea
- ☐ **P** Pressure (HTN)
- ☐ **B** BMI > 35
- ☐ **A** Age > 50
- ☐ **N** Neck: F > 15, M > 17
- ☐ **G** Gender Male

- ☐ HF (Heart Failure) NYHA Class III & IV, EF (Ejection Fraction) less than 50%, or Class II Diastolic Dysfunction
- ☐ Cardiac arrhythmia (e.g. atrial fibrillation, SVT, ventricular arrhythmia (diagnosis) ____________________
- ☐ Moderate to severe pulmonary disease (e.g. chronic respiratory disease / symptomatic lung disease / pulmonary hypertension) (diagnosis) ____________________
- ☐ Neuromuscular disease (diagnosis) ____________________
- ☐ Cognitive impairment or other social circumstances that compromise administration of a home sleep test (HST)
- ☐ Stroke within the last 12 months
- ☐ Suspicion of other sleep disorders (suspected diagnosis) ____________________
- ☐ Less than 18 years of age

Sleep Orders: PSG-Sleep Study 95810   Home Study 95806 or G3099
Is request for in-center study a Federal Aviation Association (FAA) or National Transportation Safety Board (NTSB) or other third party requirement? ☐Yes ☐No

Diagnosis-please check: ☐Obstructive Sleep Apnea ☐Obstructive Sleep Apnea (***with Excessive Daytime Sleepiness***)

Required Information: Copy of patient's insurance card and history and physical
- If pre-authorization is required, please fax a copy of the request to The Sleep Center

Sleep Study Appointment Date: ______________ Tech: ______________________________

______________________________   ______________
Physician's Signature   Date

The Center will notify you within 48 hours of scheduling status.

(MNM 371.059)
1/17/14