Sleep Specialists of The Woodlands

Fax orders to 281.738.5358
Questions? Call 281.789.4069

Follow Steps 1-3 to complete the Physician Prescription Referral Form

1 Indications/Clinical Obs.

Please Check All That Apply

- ○ Snoring
- ○ Witnessed Apnea
- ○ Restless Sleep
- ○ Excessive Daytime Sleepiness
- ○ Obesity *(or Daytime Fatigue)*
- ○ Abnormal Behavior During Sleep
- ○ Morning Headaches
- ○ Shift Work
- ○ Sleep Paralysis
- ○ Cataplexy
- ○ Drowsy Driving

2 Diagnosis

Please Check ONE

- ○ Obstructive Sleep Apnea
- ○ Periodic Limb Movement
- ○ Narcolepsy
- ○ Upper Airway Resistance Syn.
- ○ Nocturnal Seizure
- ○ Parasomnia
- ○ REM Behavior Disorder
- ○ Hypersomnia NOS
- ○ Hypersomnia w/OSA
- ○ Other

3 Services Requested

Please Check All That Apply

- ○ Diagnose and Treatment
  - Polysomnogram (PSG) 95810
  - CPAP/Bi-Level Titration 95811
  - DME Set-Up per Study Results
- ○ Polysomnogram (PSG) 95810
- ○ PSG with MSLT 95810, 95805
- ○ PSG with MWT 95810, 95805
- ○ CPAP/Bi-Level Titration 95811
- ○ CPAP/Re-Titration 95811
- ○ Split Night Study 95811
- ○ ***I DO NOT*** want a sleep physician consult
  (a sleep consult and appropriate follow-up will occur on all patients unless otherwise indicated)

I have reviewed the H&P and the patient meets requirements for a sleep study as set forth in Practice Parameters by AASM.

_____
Medical Director

Patient Information

Patient Name: _____

Patient Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Cell Ph: _____ Home Ph: _____ Work Ph: _____

Patient Height: _____ Weight: _____ Parent/Guardian: _____

Insurance Information

Primary Insurance: _____

ID: _____ Group# _____

Phone: _____

Auth/PreCert: _____

Primary Insurance: _____

ID: _____ Group# _____

Phone: _____

Auth/PreCert: _____

Referral Office Information

Physician Name: _____ UPIN# _____

Referral Person: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

I authorize Sleep Specialists of the Woodlands to preform services on the above patient according to clinical protocols approved by the Medical Director

_____ _____ _____

Physician Signature Required | Physician Name (Printed) | Date