REFERRAL FORM

PH: (562) 622-1002 • FAX: (562) 622-1058

PLEASE FAX THIS COMPLETED FORM INCLUDING SUPPORTING DOCUMENTS (DEMOGRAPHICS, INSURANCE CARD FRONT & BACK)
Fill out online @ www.statsleep.com or Email rx@statsleep.com

1 If Complete Demographic Included with this form, skip to Section 2.

PT Name: _____ **Date:** _____

Address: _____ **City:** _____ **Zip Code:** _____

PH# (Home): _____ **PH# (Cell):** _____ **Email:** _____

Date of Birth: _____ ☐ **Male** ☐ **Female**

2 If Diagnosis Included on RX, skip to Section 3.

DIAGNOSIS:

Apnea Events | Chronic Fatigue | Seizures | Insomnia | Narcolepsy | Restless Legs

Other: _____

3

Overnight Study: ☐ **COMPLETE STUDY (PSG & CPAP TITRATION STUDIES)**

☐ **95810 (PSG Sleep Test)** ☐ **95811 (CPAP Titration)** ☐ **95811 (Split Study)**

Other Sleep Test: ☐ **95807-52 PAP NAP - Ideal for Non Compliant CPAP users.**

☐ **95805 MSLT** – (Multiple Sleep Latency Test)
☐ **95805 MWT** – (Maintenance of Wakefulness Test)

☐ **95810 + 95827 Seizure Montage Study** – (checks for Nocturnal Seizures & Parasomnias)

Home Sleep Test: ☐ **95800**

☐ Consultation for sleep disorders

Physician Name: _____ **Phone #:** _____

Signature: _____ **Date:** _____

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CUT OFF