



Sleep Medicine Referral Form & ICD-9 Codes for Diagnostic Services

Patient Name: _____ DOB: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Ph: _____ Cell Ph: _____ Wk Ph: _____

Please attach related patient's clinical history, physician notes and demographics which include insurance information.

Referring Physician: _____ NPI: _____ UPIN: _____
 CA License: _____ Phone: _____ Fax: _____ Email: _____
 Address: _____ City: _____ State: _____ Zip: _____

Symptoms & Reason for Referral

<input type="checkbox"/> Witnessed/Suspected Sleep Anea	<input type="checkbox"/> Obesity <input type="checkbox"/> Diabetes	<input type="checkbox"/> Cardiac Disease	<input type="checkbox"/> COPD
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Restless Les Syndrome	<input type="checkbox"/> Mood Disorder	<input type="checkbox"/> History of OSA (327.23)
<input type="checkbox"/> Snoring	<input type="checkbox"/> Excessive daytime Sleepiness	<input type="checkbox"/> Morning Headaches	<input type="checkbox"/> Stroke

Sleep Disorders Diagnostic Services

- Please initiate treatment if positive for OSA
 CPAP _____ +/-2 cm H20
 APAP _____ - _____ +/-2 cm H20
 Bi-Level _____/_____ +/-2 cm H20
 Please provide patient with all necessary CPAP supplies (ex. mask, headgear, tubing, filters and/or humidifier) to assure compliance.
- Provide patient with a humidifier (cool or heated)
- Change patient's CPAP pressure: increase to _____ cm H20
 decrease to _____ cm H20
- Provide patient with replacement CPAP supplies
- Discontinue CPAP treatment
- Special requests: _____

Physician Signature: _____ Date: _____