Sleep Center Referral Form

Phone: (919) 645-9280
Fax: (919) 208-2149

Wake Sleep DIAGNOSIS. TREATMENT. COMPLIANCE.

Patient Name _____ Home Phone _____

Address _____ Work Phone _____

_____ Cell Phone _____

Insurance _____ Date of Birth _____

Insurance ID _____ Gender M or F

Clinical/Office notes and/or History & Physical must accompany referral prior to scheduling study.

- ☐ **Split Night Study *** (95811)
- ☐ **Polysomnography *** (95810)
- ☐ **CPAP Titration** (95811)
- ☐ **Bi-Level Titration** (95811)
- ☐ **ASV Titration** (95811)
- ☐ **PAP NAP Study** (95807)
- ☐ **M**ultiple **S**leep **L**atency **T**est (**MSLT**) (95805)
- ☐ **M**aintenance of **W**akefulness **T**est (**MWT**) (95805)
- ☐ **H**ome **S**leep **T**esting (**HST**) (95806)

***HST if required by insurance.**

Request Consult? _____ Yes _____ No

☐ I would like Wake Sleep, LLC to perform a CPAP Titration if the NPSG is abnormal.

☐ I would like for Wake Sleep, LLC to set up CPAP/Bi-Level equipment and supplies.

☐ **Comprehensive Sleep Program**
Full-Service sleep management including Sleep Study, Follow-Up Consultation, and ongoing Sleep Management.

Referring Signs/Symptoms: _____

_____

_____

Special Needs: ___ **Wheelchair** ___ **Oxygen** ___ **Caregiver** ___ **Other** _____

Ordering Physician's Information

Referring Physician _____

Practice: _____ **Phone:** _____ **Fax:** _____

Person to contact with any questions regarding this referral: _____

Physician Signature: _____ **Date:** _____