Sleep Wellness Center
get your zzzzzzz

SLEEP STUDY ORDER REFERRAL

PATIENT NAME:	☐ FEMALE ☐ MALE	DOB:	
ADDRESS:	CITY:	ST:	ZIP:
SSN:	HOME PHONE:	CELL PHONE:	
EMERGENCY CONTACT NAME:	PHONE:	RELATIONSHIP:	

INDICATIONS:	☐ OBSTRUCTIVE SLEEP APNEA (OSA) (G47.33)	☐ PERIODIC LEG MOVEMENT DISORDER (G47.61)
	☐ NARCOLEPSY (G47.41)	☐ HYPERSOMNIA, UNSPECIFIED (G47.10)
	☐ OTHER SLEEP DISTURBANCES (G47.80)	☐ OTHER:

PRIMARY INSURANCE:		PHONE:	
POLICY ID#:	GROUP #:	INSURED RELATIONSHIP:	
SUBSCRIBER/INSURED NAME:	DOB:	INSURED SSN:	
SECONDARY INSURANCE:		PHONE:	
POLICY ID#:	GROUP #:	INSURED RELATIONSHIP:	
SUBSCRIBER/INSURED NAME:	DOB:	INSURED SSN:	

PROCEDURE ORDERED:	☐ FULL POLYSOMNOGRAPHY SPLIT NIGHT WITH CPAP/BPAP IF INDICATED
	☐ FULL POLYSOMNOGRAPHY FOR CPAP/BPAP TITRATION-PREVIOUS PSG W/OSA DOCUMENTATION REQUIRED
	☐ FULL POLYSOMNOGRAPHY FOR SUSPECTED SLEEP APNEA WITH NO TITRATION
	☐ SLEEPING AID IF INDICATED -PATIENT SHOULD BRING SLEEP AID TO THE APPOINTMENT, SELF-ADMINISTER
	☐ HOME SLEEP STUDY (IF APPLICABLE)

IF MSLT IS INDICATED CHECK HERE:	☐ MULTIPLE SLEEP LATENCY TEST	
IS PATIENT CURRENTLY ON OXYGEN?	☐ YES ☐ NO	IF YES, O2 LPM =
SPECIAL INSTRUCTIONS:		

REFERRING PHYSICIAN:		PHONE:	
ADDRESS:		FAX:	
CITY:		ST:	ZIP:

PHYSICIAN SIGNATURE & DATE:	✓	**DATE:**	✓

☐ **NOTE: PLEASE FAX A COPY OF THE SLEEP QUESTIONNAIRE & CHART NOTES WITH THIS FORM**

PLEASE FAX SIGNED & DATED FORM TO: SLEEP WELLNESS CENTER – WINMAR DIAGNOSTICS: 701-239-4792

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