Sleep Unlimited, INC. fax: 662-284-9610

Corinth, MS **phone: 662-284-9502**

REFERRAL FORM
(CERTIFICATE OF MEDICAL NECESSITY)

Note: Please submit a copy of patients' current demographic sheet along with copy of Insurance Card or Insurance Information. Thank you for your referral. We will schedule your patient and notify you of date of study as soon as possible.

PATIENTS NAME: _____ DOB: _____

M ☐ F ☐ Height:_____Weight: _____ SSN# _____

PHONE: _____INSURANCE:_____

HEENT exam: (or last physician notes on chart with physical information)

☐ WNL ☐ Deviated Septum ☐ Elongated Uvula
☐ TMJ ☐ Nasal Obstruction ☐ Tonsils size
☐ Sinus Disease ☐ Mouth Breathing ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+

PRESENTING SYMPTOMS:

☐ Loud snoring ☐ Excessive daytime sleepiness ☐ Fatigue
☐ Witnessed Apnea ☐ Awakening gasping for breath ☐ Obesity
☐ Sleep Paralysis ☐ Non-restorative sleep ☐ Hypertension
☐ Morning Headaches ☐ Leg restlessness or jerks ☐ Morning Dry Mouth

TEST(s) REQUESTED:

95810 ☐ Full Polysomnography greater than six hours (all night study)
95805 ☐ Multiple Sleep Latency Tests (MSLTs)
95805 ☐ Maintenance of Wakefulness Tests (MWTs) required for DOT license
95811 ☐ Nasal CPAP/BiLevel Titration Study
95810 ☐ Surgical Follow-up (PSG)
95811 ☐ CPAP follow-up Study
95806 ☐ In – Home apnea screening (one night)
☐ Neurological Consult OR Clinic appointment with Sleep Physician

☐ DME – provided by_____

Indicate any other medical problems or special concerns: _____

_____

I have referred the above patient for a medically necessary sleep study or evaluation for the reason indicated on this form. I am aware that this patient may require two sleep studies and will be scheduled for the second study according to written protocol which states that if the RDI for the PSG is >5, the second study will then be performed to titrate CPAP to the appropriate pressure. If daytime sleepiness is present, a MSLT study may be performed per written protocol.

Referring Physician: _____ Date: _____

Patient Information Sheet

Patient Name: _____ Today's Date: _____
SS #: _____ Age: _____ Date of Birth: _____
Home Address: _____
_____

Email Address: _____
Patients Employer: _____
Occupation: _____

Referring Physician: _____
Chief Complaint: _____

Day (work) Phone: _____ Evening (home) Phone: _____
Cell Phone: _____
Spouse: _____ Employer: _____
Date of Birth: _____ Phone Number: _____

May we leave a message for your on your home or work number? _____
In the event that we are unable to reach you, with whom may we discuss your scheduling, results, and treatment?
Name: _____ Phone Number: _____

Primary Insurance Information

Insurance Company _____
Address: _____
Telephone: _____ Contact: _____
Primary Insured: _____ Insured's Date of Birth: _____
ID# _____Group/Policy#_____ Deductible: _____

Secondary Insurance Information

Insurance Company _____
Address: _____
Telephone: _____ Contact: _____
Primary Insured: _____ Insured's Date of Birth: _____
ID# _____Group/Policy#_____ Deductible: _____

Ame 3/5/05