Fax to: **914-333-5925**
Attn: Sleep Referral Coordinator
Tel: **914-333-5813**

SLEEP STUDY PRESCRIPTION REFERRAL FORM

Please check facility: ____ Phelps Memorial Hospital ____White Plains Hospital Center ____Putnam Hospital Center ____NYEE ___Englewood Hospital ____HST

PATIENT INFO:

First Name: ______________________ MI: ___ Last: ______________________________Ht:_____Wt_____ Sex: M F

Address: ________________________________ City: __________________________ State: ____ Zip: _______________

Phone: (H)______________________ (W) _____________________ Date of Birth: ______________ SS# _______________

Requesting MD: _____________________________________ Tel: ____________________ Fax: _____________________

Primary Care MD: ___________________________________ _Tel: __________________ _Fax:______________________

INSURANCE INFO: *Please submit a photocopy of the patient's insurance card* (FRONT AND BACK)

Date of pre-certification: ____________________ Primary Insurance Carrier: _____________________________________

Policy/ID#: _______________________________Second Insurance Carrier: _____________________________________

Insurance Contact Person: _________________Tel: _________________Pre-Certification #: _______________________

Comments: ____

TEST REQUESTED: (Check Applicable) **Currently on CPAP/BIPAP?** ☐ NO ☐ YES_______cmH2O

☐ PSG (95810) and follow-up CPAP Titration (95811)
(If PSG is positive, I authorize CPAP titration)

☐ CPAP Titration (95811)

☐ Split-Night study (1/2-PSG, 1/2-CPAP Titration (95811)

☐ Polysomnography (PSG) (95810)

☐ PSG with Multiple Sleep Latency Test (MSLT) (95805)

☐ **I request a consult with a sleep specialist** ☐ **before/** ☐ **after sleep study.**

INDICATIONS: (Check Applicable)

☐ Snoring (786.09)
☐ Witnessed Apnea (327.20)
☐ Daytime Sleepiness (327.1)
☐ High Blood Pressure (401.9)
☐ Shortness of Breath (786.05)
☐ Arrhythmia (427.9)
☐ OTHER______________________
☐ Obesity (278.0)
☐ Chronic Lung Disease (491.2)
☐ Post Op ENT Surgery (DATE:_________)
☐ Pre-Bariatric Surgery

SPECIAL NEEDS: (Check Applicable)

☐ Tape, latex, talc allergy ☐ Supplemental oxygen: ____________ L/min ☐ Incontinence ☐ Walker

☐ Wheelchair ☐ Translator (Language: _________________________) ☐ Other__________________

MEDICAL HISTORY: *Please attach a copy of patient's History and Physical.*

I Authorize Night and Day Sleep Services to perform sleep studies on above patient according to their protocols.

PHYSICIAN: ___________________________ SIGNATURE: ______________________________ DATE: __________________
(Please print ordering physician name)