



SLEEP STUDY REFERRAL FORM – PLEASE FAX TO 914.631.7852

Patient: _____ Sex: _____ DOB: _____ SSN: _____
 Address: _____ City/State/Zip: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Insurance: _____ ID#: _____ Group #: _____
 Insured Name: _____ Insured DOB: _____ Insured SSN: _____

TYPE OF STUDY REQUESTED:

- I would like my patient seen in consultation with the Sleep Specialist: Before testing After testing
- Comprehensive PSG, CPAP (if AHI>5 on NPSG). Please Note: After the sleep study, for home BiPAP/CPAP needs, please complete a DME form and send it to a DME vendor of your choice.**
- Nocturnal polysomnogram (NPSG) 95810 CPAP titration study 95811
- Split night study (NPSG/CPAP) Non-invasive ventilation titration study for hypoventilation 95811
- NPSG with Multiple Sleep Latency Test (MSLT) 95805 Maintenance of Wakefulness Test (MWT) 95805
- Administer supplemental O₂ at _____ L/min Pt. has trach, do study (circle: **Opened** or **Closed**)

Special Instructions/Needs: _____

MEDICAL DOCUMENT: Please attach medical record that necessitated the sleep referral

MEDICARE PATIENTS: History/Physical notes of office visit must accompany this referral. Also please complete the vitals listed.

Height: _____ Weight: _____ BMI: _____ Neck Circumference: _____

Suspected Sleep Condition Resulting in Referral (MUST CHECK AT LEAST ONE):

- Sleep Apnea (G47.33) Restless Sleep (G47.8) Periodic Limb Movements (G47.61)
- REM Behavior Disorder (G47.52) Sleepiness (G47.10) Sleep Walking (F51.3)
- Night Terrors (F51.3) Narcolepsy (G47.419) Hypoventilation (G47.36)

Indication for Polysomnography/ Symptoms (must check at least TWO):

- Snoring Waking with a headache
- Excessive daytime sleepiness Waking feeling tired
- Witnesses pauses in breathing while asleep Restless sensation in arms or legs
- Awaken with gasping or choking sensation Kicking movements while asleep
- Difficulty falling asleep or staying asleep Impaired daytime concentration/memory or mood change
- Sleep paralysis Sudden loss of muscle strength brought on by strong emotion
- Other: _____

Medical History

- Hypertension Congestive Heart Failure Seizures
- Pulmonary hypertension Asthma Emphysema
- Diabetes Nasal obstruction Obesity
- Cardiac problems Nocturnal reflux/GERD Stroke
- Mood disorder Other psychiatric illness (specify) _____
- Currently on CPAP/Bi-Level _____ cm H₂O Previous Sleep Study (location & date): _____
- ALLERGIES (Please Note):** _____

I AUTHORIZE THE BROOKLYN HOSPITAL SLEEP CENTER TO PERFORM A SLEEP STUDY ON ABOVE PATIENT ACCORDING TO THEIR PROTOCOLS, INCLUDING URGENT INITIATION OF OXYGEN & CPAP.

Physician Name: _____ Signature: _____
 Date: _____ NPI: _____ License #: _____
 Address: _____ City/State/Zip: _____
 Phone: _____ Fax: _____ Email: _____ Specialty: _____

After completing, please fax to 914.631.7852