California Sleep, Inc. **Sleep Study Referral Form**

PATIENT INFORMATION	
Patient Name:	DOB:
Street Address:	Insurance:
City, State, Zip:	Insurance ID #:
Primary Phone:	SSN:
Symptoms / Reason for Referral: (Snoring, Witnessed Apneas, EDS, Morning Headaches, Insomnia, Other)	
Diagnosis / ICD-10 Codes:	
Height / Weight:	
Neck Circumference / BMI:	
Epworth Sleepiness Score:	
Additional Notes / Instructions:	
Type of study ordered:	
☐	95782 – Pediatric Polysomnography (sleep staging with 4+ parameters, <6 years)
☐	95810 – Diagnostic Polysomnography (sleep staging with 4+ parameters, ≥6 years)
☐	95811 – Split-Night / PAP Titration Study
☐	Other:
EXISTING PAP INFORMTION (if applicable):	
Current PAP User	
Pressure Settings:	
DME Provider:	
REFERRING PROVIDER INFORMATION	

Printed Name	Signature	NPI	Date

Please fax or email completed referral form with:	
• Copy of insurance card(s)	• Clinical notes supporting medical necessity
• Most recent office visit notes	• Most recent sleep study results (if any)

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