Mountain Heart™
Sleep Facility

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Sleep Facility Referral Form

☐ Flagstaff ☐ Verde Valley

Patient Name: _____ DOB: _____ Date: _____

Referring Provider (print): _____ Provider Phone: _____

Is patient currently on PAP therapy : Y N
If yes, what pressure _____

Does patient require Oxygen: Y N
If yes, what liter flow_____

Diagnosis: (Please check all that apply)

- ☐ Obstructive Sleep Apnea (G47.83)
- ☐ Central Sleep Apnea (G47.31)
- ☐ Sleep Disturbance (G47.8)
- ☐ Hypoxemia (R09.02)
- ☐ Snoring (R06.83)
- ☐ Narcolepsy with w/out Cataplexy (G47.419)
- ☐ Drowsiness / Somnolence (R40.0)
- ☐ Insomnia w/Sleep Apnea (G47.01)
- ☐ Hypertension (I10)
- ☐ Restless Leg Syndrome / Periodic Limb movements (G25.81)
- ☐ Obesity (E66)
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Please select one of the following treatment options:

☐ **Complete Sleep Management: Consult with sleep specialist for evaluation, testing, equipment and continuance of care.**

TEST ONLY

☐ Diagnostic Sleep Study (Baseline) (95810)

- o If positive for OSA, initial here to have patient return for CPAP Titration : _____

☐ Split-Night Sleep Study (95810-95811)

- o If the patient needs further CPAP Titration initial here for patient to return : _____
- o Lab policy is to split for safety if AHI > 40. Initial here if split is contraindicated : _____

☐ Positive Airway Pressure (PAP) Titration Sleep Study (95811): □CPAP □BiLevel
☐ Polysomnography with Multiple Sleep Latency Test (PSG with MSLT)(95810/95811/95805)
☐ Maintenance of Wakefulness Test (MWT) (95805)
☐ Adapto Servo Ventilation (ASV) Titration (95811)
☐ Maintenance Wakefulness Test (MWT) (95805)
☐ Oral Appliance Efficacy Study (95810)
☐ Split Night Oral Appliance Efficacy (95811)
☐ Home Sleep Apnea Test (HSAT) (95806)

In order to ensure that your patient's consultation or sleep test is performed as soon as possible we require the following: a copy of patient demographics and insurance cards, recent progress notes detailing sleep symptoms and reason for sleep study, previous pertinent test results including any sleep studies. Please FAX this information to our facility.

Referring Physicians Signature: _____ Date: _____

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