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Z SLEEP DIAGNOZTICS

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# PATIENT REFERRAL FORM

Patient Name: _____ Phone: _____
DOB: _____ Insurance Member ID: _____

## Diagnostic and Therapeutic Procedures

□ **Diagnostic Sleep Study** (95810)

□ **Sleep Study with CPAP/Bilevel Titration** (split night) (95811)

□ **CPAP/Bilevel Titration** (diagnostic portion completed) (95811)

□ **Multiple Sleep Latency Test** (MSLT) (95805)

□ **Maintenance of Wakefulness Testing** (MWT) (95805)

□ **Pulse Oximetry** (94762) □ overnight □ on room air □ with CPAP □ with oxygen

□ **Home Sleep Test** (95806)

**Sleep Study Presenting Symptoms** Ht: _____ Wt: _____

___ Snoring ___ Excessive Daytime Somnolence ___ Non Restorative sleep
___ Leg Restlessness ___ Observed Apnea ___ Hypoxemia
___ Morning Headaches ___ Sleep Paralysis
Other: _____

## CPAP or Bilevel Therapy

□ **CPAP** (E0601) **_____ cm H2O** □ **Auto Titrating CPAP _____ to _____ cm H2O**

□**Bilevel _____ IPAP _____ EPAP cm H2O**

□ **Bilevel Auto ASV ____ / ____ / ____ cm H2O**

□ **Heated Humidifier for chronic sinus symptoms and/or allergies** (E0562)

□ **All Disposables** (mask, headgear, tubing, filters)

**Medical Necessity:**

Diagnosis: *Obstructive Sleep Apnea G47.33* Estimated length of need (number of months) _____
1 – 99 ( 99 = Lifetime)
Description of Medical Equipment Prescribed: *CPAP or BIPAP & Supplies, heated humidifier for chronic sinusitis.*
Comments _____

_____ _____ _____
Signature of Physician Physician Printed Date