**Goodnite Sleep Solution**
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# REFERRAL FORM

## PATIENT INFORMATION:

Patient Name: _____ Order Date: _____
Identifier/Record: _____ Ordering Physician: _____
Home Phone #: _____ Work Phone #: _____
Insurance: _____
Authorization #: _____

Scanned Date: _____

Arrival Time (circle one) **8:00PM** **9:00PM** Rescheduled Scanned Date: _____

**Internal use only:** *(date and initials)*
No Show: _____
Reschedule Date: _____
Info Sheet to Pt._____ Date Scored: _____
Confirmation Call Day of Study: _____ Scoring Tech: _____
Reports Visit/Call Date: _____ Recording Tech: _____

Diagnosis for Test Below: Obstructive Sleep Apnea G47.33; Hypersomnia NOS G47.10; Hypersomnia due to medical condition G47.14; Idiopathic Hypersomnia w/long sleep time G47.11; Idiopathic Hypersomnia without long sleep time G47.12; Narcolepsy w/cataplexy 347.00 (G47.411); Narcolepsy w/o Cataplexy 347.01 (G47-419); Insomnia NOS 780.52 (G47.00); Obesity Hypoventilation syndrome E66.2; Sleep related non-obstructive Alveolar Hypoventilation G47.34; REM sleep behavior disorder 327.42(G47.52)

## SLEEP CENTER TESTING PROTOCOL-ORDER:

- ☐ **Diagnostic Polysomnogram** (Comprehensive sleep study / "PSG") (**CPT 95810**)
- ☐ **Split Night Polysomnogram** (Comprehensive sleep study + CPAP titration or other therapy) (**CPT 95811**)
  *(For therapy other than Cpap please add details in "special instructions" section below)*
  *Split after AHI of _____ .* ***A REM period is or is not required before splitting.***
- ☐ **REM Preferred 2 AM Split**
- ☐ **CPAP Titration Polysomnogram** (Full night of CPAP at a fixed or titrated level) (**CPT 95811**)
- ☐ **MSLT** (Multiple Sleep Latency Test following overnight PSG) (**CPT 95805**)
- ☐ **MWT** (Maintenance of Wakefulness Test following overnight PSG) (**CPT 95805**)
- ☐ **Limited Polysomnogram** (Cardio-respiratory recording w/o EEG)
- ☐ **IN-HOME SLEEP TEST** Overnight sleep test-pick up and return from our office. (**CPT 95806**)

## ORDERING OPTIONS:

- ☐ Lights out preferred: _____AM/PM Lights on preferred:_____AM/PM
- ☐ Oxygen via: nasal cannula at _____L/min: Entrained into CPAP/Bilevel mask at _____L/min;
  Via mask (plain; venturi) at FIO2 _____or _____ L/min.
- ☐ Do not use supplemental oxygen unless additional order is given.
- ☐ Hypnotic needed: (Rx to patient or patient to bring meds to lab)
- ☐ Do not take _____
- ☐ Patient to take all medications: _____

Relevant Medications: _____
Problems:
Diabetes Mellitus: Y / N Atrial Fib (or PAF): Y / N Pacemaker: Y / N

**SPECIAL INSTRUCTIONS**: (*please add **specific** changes to protocol or montage here*)

_____
_____
_____

**Signature**: _____ **Date:** _____