

Texas Pulmonary Sleep Center Sleep Study Direct Referral

Thank you for referring your patient for a sleep study evaluation. We require the following completed information to be faxed to (817) 860-8772 along with the patient's insurance information prior to patient acceptance and scheduling. For more information please call the office at (817) 461-8772. We appreciate your patience and cooperation!

Referring physician: _____ UPIN: _____ NPI#: _____

Office address to submit test results: _____

Nurse: _____ Office Contact Name: _____

Office Contact Ph #: _____ Fax #: _____ E-Mail: _____

Patient's name: _____ DOB: _____ Sex: _____ Marital Status: _____

Cell #: _____ Home ph#: _____ Work ph #: _____

Do you consent to have your patient receive a pre-study consultation by one of our sleep lab physicians? [] Yes [] No

***Please note that patients who are NOT evaluated by one of our sleep lab physicians must have the medical information section below completed by the referring physician or nurse before the patient can be approved for sleep study scheduling.**

**M
E
D
I
C
A
L

I
N
F
O
R
M
A
T
I
O
N**

Suspected Diagnosis & ICD-9 Code (Check appropriate boxes):

- | | | |
|--|--|---|
| <input type="checkbox"/> Obstructive Sleep Apnea (OSA) <u>327.23</u> | <input type="checkbox"/> Hypersomnia <u>327.10</u> | <input type="checkbox"/> Seizures <u>780.39</u> |
| <input type="checkbox"/> Shortness of breath <u>327.20</u> | <input type="checkbox"/> Narcolepsy <u>347.00</u> | <input type="checkbox"/> Insomnia <u>307.42</u> |
| <input type="checkbox"/> Central Sleep Apnea <u>786.04</u> | <input type="checkbox"/> Sleep Enuresis <u>788.36</u> | <input type="checkbox"/> Parasomnia <u>327.40</u> |
| <input type="checkbox"/> Restless Legs Syndrome <u>333.99</u> | <input type="checkbox"/> Periodic Limb Movement Disorder <u>327.51</u> | |
| <input type="checkbox"/> Other (specify with ICD-9 Code) _____ | | |

Sleep History/Symptoms (Check appropriate boxes):

- | | | | |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Muscle/joint aches | <input type="checkbox"/> Limb jerks/twitches | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Witnessed apneas | <input type="checkbox"/> Wakes up choking | <input type="checkbox"/> Restlessness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Frequent nightmares | <input type="checkbox"/> Difficulty initiating sleep | <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Morning headaches | <input type="checkbox"/> Sleep paralysis (Cataplexy) | <input type="checkbox"/> Frequent enuresis | <input type="checkbox"/> Dyspnea |
| <input type="checkbox"/> Nocturnal teeth grinding (Bruxism) | <input type="checkbox"/> Fatigue or Malaise | <input type="checkbox"/> Acts out dreams (REM Behavior Disorder) | |
| <input type="checkbox"/> s/p UA surgery for OSA (list procedures): _____ | | | Date: _____ |

Relevant Medical History (Check appropriate boxes):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> Pulmonary hypertension | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> CHF |
| <input type="checkbox"/> Pulmonary disease (COPD) | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Latex allergies |
| <input type="checkbox"/> Cardiac Arrhythmia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> CAD |
| <input type="checkbox"/> Other: _____ | | | |

**O
R
D
E
R
S**

Sleep Study Orders (Check appropriate boxes):

- All night PSG for diagnostic evaluation* (95810)
- All night Titration PSG with Positive Airway Pressure (PAP) applied throughout study (95811)
- Narcolepsy Screen (Overnight Polysomnography followed by daytime MSLT)
- Multiple Sleep Latency Test/MSLT or Maintenance of Wakefulness Test/MWT (95805)
- Overnight Pulse Oximetry Screening (94762)
- Supplemental O2 applied throughout testing (without meeting sleep lab O2 protocol). **RX: O2 @ _____ lpm via NC or mask.**
- Other: _____

Has the patient had a previous PSG? [] No [] Yes If yes, where? _____ When? _____
Outcome? _____

Special Needs/Requirements (currently):

[] Oxygen [] Wheelchair [] Recliner [] Bed Pads [] Caretaker [] Communication Barriers: _____

Do you want the sleep lab to set the patient up on CPAP if indicated from this sleep study? [] Yes [] No

Ordering physician's signature: _____ Date Ordered: _____

SLEEP LAB USE ONLY:

_____ Approved _____ Not approved Comments: _____
Medical Director's Signature _____ Date _____