Phone (231) 642-5124
Fax (866) 306-2874

Referral Form

PATIENT INFORMATION	PROVIDER INFORMATION
Name:________________	Name:________________
PCP:________________	NPI #:________________
DOB:__________ Gender: M ☐ F ☐	Address:________________
Phone #:________________	Phone #:________________
Address:________________	Fax:________________

Ht: Wt: BMI: :

Home Sleep Study (G0399 Home Sleep Study, 95806, 95800)

Clinical History *(check all that apply)*

- ☐ Snoring
- ☐ Witnessed apnea
- ☐ Excessive daytime sleepiness
- ☐ Morning headaches
- ☐ Non-Restorative sleep
- ☐ Dry mouth
- ☐ Choking/Gasping during sleep
- ☐ Nocturnal arousals

Comorbidities *(check all that apply)*

- ☐ Obesity
- ☐ GERD
- ☐ TIA or Stroke *(>6 months)*
- ☐ A-Fib
- ☐ Depression
- ☐ ADD/ADHD
- ☐ HTN
- ☐ CAD
- ☐ OSA

Provider Name:________________________________

Provider Signature: ________________________ Date: __ /__ /__

Please fax order and demographics to (866) 306-2874.