Neuro Diagnostic Sleep Centers

Phone Number: (602) 424-4450
Scheduling Fax: (602) 424-4451
Alt. Scheduling Fax: (602) 354-8531

Date: _____

Referring Physician: _____

Patient Demographics	Insurance Card (Front & Back)	Relevant Medical History
◯ Included ◯ To Follow	◯ Included ◯ To Follow	◯ Included ◯ To Follow

Has your patient had a previous sleep study? ◯ Yes ◯ No **If yes, previous results are:** ◯ Included ◯ Not Available

Patient Name: _____ **Phone:** _____

DOB: _____ SSN: _____ Alt Phone: _____

Primary Language: ◯ **English** ◯ **Spanish** ◯ **Other Language:** _____

Insurance: _____ Policy No: _____

Adjustor: _____ Claim/File No: _____ Auth No: _____

Diagnosis: _____ ICD-9: _____

PLEASE NOTE: Insurance companies now require that the patient have a face to face consultation before being placed on PAP therapy

SYMPTOMS: (Please check all that apply)

- ☐ Witnessed Apnea
- ☐ Obesity
- ☐ Hypertension
- ☐ Excessive Daytime Sleepiness / Fatigue
- ☐ Persistent / Frequent Snoring
- ☐ Diabetes
- ☐ COPD
- ☐ Cardiovascular Disease
- ☐ Periodic Limb Movement (RLS)
- ☐ Choking / Gasping Associated with Awakening
- ☐ Patient on O_2 Therapy
- ☐ Other: _____

DIAGNOSTIC SLEEP STUDIES: (Please select one from the list below)

In Lab Sleep Study (PSG)	In Lab Split Night Study (PSG & Titration)	Home Sleep Study (HST)	In Lab Titration
◯ With Consultation	◯ With Consultation	◯ With Consultation	◯ With Consultation
◯ Without Consultation*	◯ Without Consultation*	◯ Without Consultation*	◯ Without Consultation*

* If diagnostic sleep study is performed without conslutation, the referring physician will be responsible for managing the patient through the sleep process including all therapy and follow-up.

☐ Additional Medical Request: _____

Referring Physician: _____ Fax: _____

Referral Coordinator: _____ Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Referring Physician Signature: _____

APPOINTMENT INFORMATION:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Date: _____ At _____ A.M. / P.M.

Location: _____

Please Note:
To avoid a no-show fee,
72 hours advanced notice
of cancellation is required.

For locations and additional information, please visit: **www.ndxlabs.com**

Referring Physician will have results immediately upon completion. Please call if you need clarification or a more specific exam.