



**Date:** \_\_\_\_\_

**Referring Provider & Clinic:** \_\_\_\_\_

Patient Demographics	Insurance Card (Front & Back)	All Relevant Notes Dating Back 90 Days
<input type="checkbox"/> Included <input type="checkbox"/> To Follow	<input type="checkbox"/> Included <input type="checkbox"/> To Follow	<input type="checkbox"/> Included <input type="checkbox"/> 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: \_\_\_\_\_  
 Adjuster: \_\_\_\_\_ Claim/File No: \_\_\_\_\_ Auth No: \_\_\_\_\_  
 PCP Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_

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

**SYMPTOMS:** (Please check all that apply)

<input type="checkbox"/> Witnessed Apnea	<input type="checkbox"/> Persistent / Frequent Snoring	<input type="checkbox"/> Periodic Limb Movement (RLS)
<input type="checkbox"/> Obesity	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Choking / Gasping Associated with Awakening
<input type="checkbox"/> Hypertension	<input type="checkbox"/> COPD	<input type="checkbox"/> Patient on O <sub>2</sub> Therapy
<input type="checkbox"/> Excessive Daytime Sleepiness / Fatigue	<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Insomnia
<input type="checkbox"/> 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
<input type="checkbox"/> With Consultation <input type="checkbox"/> Without Consultation*	<input type="checkbox"/> With Consultation <input type="checkbox"/> Without Consultation*	<input type="checkbox"/> With Consultation <input type="checkbox"/> Without Consultation*	<input type="checkbox"/> With Consultation <input type="checkbox"/> Without Consultation*

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

Additional Medical Request: \_\_\_\_\_

Referring Provider: \_\_\_\_\_ Fax: \_\_\_\_\_

Referral Coordinator: \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Referring Provider Signature:** \_\_\_\_\_

**APPOINTMENT INFORMATION:**

Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday

Date: \_\_\_\_\_ At \_\_\_\_\_ A.M. / P.M.

Location: \_\_\_\_\_

**Please Note: To avoid a no-show fee, advanced notice of cancellation is required 72 hours prior to test and 24 hours prior to consult.**

For locations and additional information, please visit: [www.ndxlabs.com](http://www.ndxlabs.com)

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