The Bon Secours Sleep Disorder Institute
Of Bon Secours Community Hospital
30 Canal St., Port Jervis, NY 12771
Phone (800) 540-4485 Fax (888) 367-6555

SLEEP STUDY REFERRAL FORM

PATIENT INFORMATION:

NAME:_____ **HEIGHT:**_____ **WEIGHT:** _____ **DOB:** _____ **SEX:**____
SOCIAL SEC. #_____ **ADDRESS:** _____
HOME PHONE:_____ **CITY/ST/ZIP:** _____
WORK PHONE:_____ **CELL PHONE/OTHER#**_____

INSURANCE INFORMATION:

INSURED NAME: _____ **INSURED SS#:**_____ **INSURED DOB:** _____
INS. CO._____ **I.D. #**_____**GROUP #**_____

PHYSICIAN INFORMATION:

NAME:_____ **PHONE:**_____
ADDRESS:_____ **FAX:**_____
CITY/ST/ZIP:_____ **SPECIALTY:**_____
SEND REPORT TO ABOVE: ☐YES ☐NO IF NO, SEND TO ADDRESS/FAX:_____

STUDY REQUESTED: History/Physical notes of office visit must accompany this referral

☐	**FULL SERVICE - PSG, If Positive (AHI>15) Follow with Titration & CPAP Placement for Home Use**	
☐	Diagnostic Sleep Study – Polysomnogram (PSG)	CPT-95810
☐	Titration with Nasal CPAP or BIPAP (circled which is preferred)	CPT-95811
☐	PSG w/Multiple Sleep Latency Test (MSLT)	CPT-95810 & 95805
☐	PSG w/Maintenance of Wakefulness Test (MWT)	CPT-95810 & 95805

SPECIAL INSTRUCTIONS / NEEDS:_____

Patient has a trach? ☐Yes ☐No If yes, do you wish trach ☐OPEN ☐CLOSED
Patient on Supp. Oxygen? ☐Yes ☐No If yes, do you wish O2 during the test? ☐Yes ___L/min ☐No

I would like my patient seen in consultation with the Sleep Specialist ☐Before ☐After testing.

REFERRING DIAGNOSIS: (Must check at least ONE)

☐ Sleep Apnea (327.23)	☐ Restless Sleep (780.56)	☐ Periodic Limb movements (327.51)
☐ REM Behavior Disorder (327.42)	☐ Sleepiness (780.54)	☐ Sleep Walking (307.46)
☐ Night Terrors (307.46)	☐ Narcolepsy (347.00)	☐ Hypoventilation (327.26) ☐ Other

INDICATIONS: (Must check at least TWO)

☐ Snoring	☐ Morning headaches	☐ Waking feeling tired
☐ Daytime sleepiness/napping	☐ Leg kicking while asleep	☐ Restless sensation in arms/legs
☐ Witnessed apnea	☐ Restless sleep	☐ Awaken with gasping or choking sensation
☐ Difficulty falling/staying asleep	☐ Impaired cognition	☐ Irritability
☐ Sleep paralysis	☐ Sudden loss of muscle strength brought on by strong emotion	

☐ Other: _____

MEDICAL HISTORY: (Must check all that apply or NONE)

☐ Hypertension	☐ Congestive Heart Failure	☐ Obesity
☐ Pulmonary Hypertension	☐ Asthma	☐ Emphysema
☐ Diabetes	☐ Nasal Obstruction	☐ Seizures
☐ Cardiac Problems	☐ Nocturnal Reflux/GERD	☐ Stroke
☐ Mood Disorder	☐ Other _____	☐ **NONE**

☐ Previous Sleep Study (location & date): _____ ☐ Currently on CPAP/Bi-Level _____cm H2O
☐ **ALLERGIES (Please Note):** _____

I AUTHORIZE SSA TO PERFORM SLEEP STUDIES ON ABOVE PATIENT ACCORDING TO THEIR PROTOCOLS, INCLUDING URGENT INITIATION OF O2 & CPAP.

PHYSICIAN SIGNATURE:_____**DATE:**_____