SLEEP DISORDERS CENTER AT

TEXAS NEUROLOGY

REFERRAL FORM

ACCREDITED MEMBER CENTER

Patient Name: _____ Patient DOB: _____

Patient Primary Phone: _____ Date: _____

Referring Physician: _____ Referring Physician Phone: _____

Please fax completed form with <u>patient demographics and a copy of patient's last office Visit notes indicating study requested</u> to our Sleep Coordinator at (214) 443-5194.
You may check the status of the referral with the Sleep Coordinator directly at (214) 443-5154.
Thank you for your referral to the Sleep Disorders Center at Texas Neurology!

SERVICES

- ❑ Sleep Medicine Consultation
- ❑ Sleep Tests
  - ❑ Polysomnogram (In-Lab Sleep Study)
  - ❑ Positive Airway Pressure Titration
  - ❑ Split Night Study
  - ❑ Multiple Sleep Latency Test
- ❑ Home Sleep Study

May a Home Sleep Study be done if an in-lab Sleep test is denied by insurance?

- ❑ Yes
- ❑ No

Diagnosis

- ❑ F51.12 (Insufficient Sleep Syndrome)
- ❑ **G47.00 (Insomnia with Obstructive Sleep Apnea, Unspecified)**
- ❑ G47.10 (Organic Hypersomnia, Unspecified)
- ❑ G47.10 (Hypersomnia with Sleep Apnea, Unspecified)
- ❑ **G47.13 (Recurrent Hypersomnia)**
- ❑ G47.20 (Circadian Rhythm Sleep Disorder, Unspecified Type)
- ❑ G47.30 (Organic Sleep Apnea, Unspecified includes Unspecified Sleep Apnea)
- ❑ G47.31 (Primary Central Sleep Apnea)
- ❑ **G47.33 (Obstructive Sleep Apnea)**
- ❑ **G47.37 (Central Sleep Apnea/Complex Sleep Apnea)**
- ❑ **G47.39 (Other Organic Sleep Apnea)**
- ❑ G47.411 (Narcolepsy with Cataplexy)
- ❑ G47.419 (Narcolepsy without Cataplexy)
- ❑ G47.50 (Organic Parasomnia, Unspecified)
- ❑ G47.51 (Confusional Arousals)
- ❑ G47.52 (REM Sleep Behavior Disorder)
- ❑ G47.53 (Recurrent Isolated Sleep Paralysis)
- ❑ G47.59 (Other Organic Parasomnia)
- ❑ **G47.61 (Periodic Limb Movement Disorder)**
- ❑ G47.69 (Other Organic Sleep Related Movement Disorders)
- ❑ R06.3 (Cheyne-Stokes Respiration)
- ❑ Other (Please specify):_____

Comorbidities Recommended for Testing

- ❑ Neuromuscular Disease
- ❑ Stroke
- ❑ Epilepsy
- ❑ Congestive Heart Failure
- ❑ Obesity BMI > 45 or 50
- ❑ Periodic Limb Movement Disorder
- ❑ Parasomnia
- ❑ Narcolepsy
- ❑ Central or Complex Apnea
- ❑ Hypertension

Notes: _____

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Referring Physician's Signature: _____ Date: _____

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Dallas, TX 75206-5202
Phone: 214-443-5154 Fax: 214-821-4017