



# REFERRAL SHEET

DATE: \_\_\_\_\_ NPI # \_\_\_\_\_  
 ORDERING PHYSICIAN: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
 PATIENT NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 HOME PHONE: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_  
 SS #: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 DATE OF LAST CLINIC VISIT: \_\_\_\_\_  
 LIST CURRENT MEDICATIONS: \_\_\_\_\_

### SYMPTOMS: Circle all that apply

- WITNESSED APNEAS
- WAKING UP GASPING/CHOKING
- DAYTIME SLEEPINESS
- SNORING
- FATIGUE
- MORNING HEADACHES
- NIGHT SWEATS

### DIAGNOSIS: Circle all that apply

- HIGH BLOOD PRESSURE
- MOOD DISORDER
- OBESITY
- STROKE
- HEART DISEASE: whether congestive heart failure or coronary artery disease
- DIABETES
- ATRIAL FIBRILLATION

### TYPE OF TEST

- PRE SLEEP EVALUATION
- PSG (1st NIGHT)
- CPAP TITRATION (2nd NIGHT)
- SPLIT NIGHT
- CPAP FOLLOW UP
- CPAP MACHINE
- DME PREFERENCE \_\_\_\_\_
- MULTIPLE SLEEP LATENCY TEST (MSLT)
- MAINTENANCE OF WAKEFULNESS TEST (MWT)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 PHYSICIAN'S SIGNATURE DATE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 PHYSICIAN'S PRINTED NAME DATE

Medicare requires a legible identifier for services provided/ordered. The method used shall be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes.

- Have interpretative results sent to me.
- I would like to perform interpretation and I will bill for interpretation.

### LOCATIONS

- Alexandria Fax: (318) 619-9590 Phone: (866) 753-3777
- Leesville Fax: (337) 289-0243 Phone: (866) 753-3777
- Baton Rouge Fax: (225) 761-7894 Phone: (225) 761-7893
- Metairie Fax: (985) 726-7278 Phone: (866) 753-3600
- Lafayette Fax: (337) 289-0243 Phone: (866) 753-3777
- Slidell Fax: (985) 726-7278 Phone: (866) 753-3600
- Lake Charles Fax: (337) 474-8565 Phone: (866) 753-8555

Please fax completed Referral, Insurance Information, Demographic Sheet, Physician Notes and a List of Current Medications.