California Sleep Solutions
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Clinical Referral Form

Patient Information

Patient Name:_____ Gender: ☐Male ☐ Female SSN:___-___-____DOB:____/____/_____

Address:_____City:_____State:_____Zip:_____

Home Phone:(_____)_____-_____Work Phone:(_____)_____-_____Mobile Phone:(_____)_____-_____

Insurance

Primary Carrier:_____Subscriber ID:_____Group:_____

Secondary Carrier:_____Subscriber ID:_____Group:_____

Referring Physician Information

Physician Name: _____Office Contact: _____

Phone:_____Fax:_____NPI: _____

Address:_____City:_____State:_____Zip:_____

SLEEP STUDY SERVICES

❑	95810/95811	Split Night Study (if criteria is met)	½ night Polysomnography, ½ night CPAP Therapy
❑	95811	CPAP Titration Only	Full night CPAP therapy
❑	95811	CPAP/BiPAP Titration	Full night CPAP/BiPAP therapy
❑	95811	ASV Titration	Full night ASV titration (echocardiogram recommended)
❑	95810	Polysomnography (PSG) only	In Lab Diagnostic Procedure
❑	95807	PAP Nap	Daytime trial of PAP to acclimate to therapy
❑	95810/ 95805	PSG Followed by Multiple Sleep Latency Test (if criteria is met)	Daytime study following PSG for excessive sleepiness or screening for narcolepsy or hypersomnia
❑	95810/ 95805	PSG Followed by Maintenance of Wakefulness Test (if criteria is met)	Daytime study following PSG to measure daytime alertness
❑	95782	Pediatric PSG	Full Night PSG; under 6 years old
❑	99243	Consultation	Consultation with Sleep Specialist
❑	Other_____		(Please specify)

Special Instructions (i.e. O_2 requirements)_____

PRIMARY SYMPTOMS

- ❑ Loud snoring
- ❑ Observed apnea
- ❑ Irregular breathing
- ❑ Gasping breathing
- ❑ Excessive daytime sleepiness with Epworth >10

ASSOCIATED CONDITIONS

- ❑ PULMONARY HYPERTENSION
- ❑ HISTORY OF STROKE
- ❑ HIGH BLOOD PRESSURE
- ❑ INSOMNIA
- ❑ CONGESTIVE HEART FAILURE
- ❑ HEART DISEASE
- ❑ MOOD DISORDER
- ❑ DEPRESSION
- ❑ CARDIAC ARRHYTHMIA
- ❑ IMPAIRED COGNITION
- ❑ NARCOTIC MEDICATIONS
- ❑ MORBID OBESITY

MEDICAL DIAGNOSIS

For medical necessity, please check all that apply:

- ❑ G47.33 OBSTRUCTIVE SLEEP APNEA
- ❑ G47.10 HYPERSOMNIA, UNSPECIFIED
- ❑ R09.02 HYPOXEMIA
- ❑ E66.01 MORBID OBESITY
- ❑ G47.429 ORGANIC HYPERSOMNIA, UNSPECIFIED
- ❑ G47.31 PRIMARY CENTRAL APNEA
- ❑ G47.36 SLEEP RELATED HYPOVENTILATION / HYPOXEMIA IN CONDTIONS CLASSIFIABLE ELSEWHERE
- ❑ G47.37 CENTRAL SLEEP APNEA IN CONDITIONS CLASSIFIED ELSEWHERE
- ❑ G47.52 REM SLEEP BEHAVIOR DISORDER
- ❑ G47.419 NARCOLEPSY, WITHOUT CATAPLEXY
- ❑ G47.411 NARCOLEPSY, WITH CATAPLEXY
- ❑ G47.8 OTHER SLEEP DISTURBANCES
- ❑ OTHER:_____ (PLEASE SPECIFY)

Physician Signature:_____Date:_____

BY SIGNING ABOVE, I AUTHORIZE THE USE OF THIS DOCUMENT AS A LEGAL PRESCRIPTION, AND CERTIFY THAT THE PRESCRIBED IS MEDICALLY NECESSARY, REASONABLE AND NOT BEING PRESCRIBED FOR CONVENIENCE.

Thank you for your referral! Please fax **this form** together with copies of the patient's **insurance cards**, **clinical notes** and **diagnostic screening** to **916.789.0529**. Please contact us with any questions at 916.789.0112.