California Sleep Solutions
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HSAT 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

❑	95806/95800	Home Sleep Apnea Test (HSAT)	Unattended Type III sleep study
❑	94660	Auto Titrating Device (7 days)	Unattended auto titrating PAP
❑	94762	Nocturnal Pulse Oximetry	Unattended Overnight blood oxygen level monitor
❑	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 (medical necessity for Type I attended in-lab polysomnography)

- ❑ CENTRAL SLEEP APNEA
- ❑ "COMPLEX" SLEEP APNEA
- ❑ NARCOLEPSY
- ❑ PARASOMNIAS
- ❑ HISTORY OF STROKE
- ❑ MORBID OBESITY BMI >35 KG/M^2
- ❑ INSOMNIA
- ❑ CONGESTIVE HEART FAILURE
- ❑ HEART DISEASE
- ❑ PULMONARY DISEASE
- ❑ NEUROMUSCULAR DISEASE
- ❑ PERIODIC LIMB MOVEMENT DISORDER (PLMD)
- ❑ CIRCADIAN RHYTHM DISORDERS

AASM Clinical Guidelines for Use of Unattended Portable Monitoring state that the above conditions prove medical necessity for a Type I in-lab PSG v. HSAT.[1]

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 CONDITIONS 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 screener** to **916.789.0529**. Please contact us with any questions at 916.789.0112

Reference 1. Collop, Nancy A., et al- Clinical Guidelines for the use of unattended portable monitors in the diagnosis of obstructive sleep apnea in adult patient. Journal of Clinical Sleep Medicine, Vol 3, No. 7, 2007