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

- ❑ Perform diagnostic sleep study – Type of study performed based on insurance criteria and patient comorbidities at labs discretion.
  - 95800/95806 Home Sleep Apnea Test (HSAT)
  - 95810/95811 Polysomnography (PSG) only or Split Night Study
  - 95782 Pediatric Polysomnography Age < 6
- ❑ 95811 CPAP/BiPAP Titration – Full night CPAP/BiPAP therapy
- ❑ 95811 ASV Titration – Full night ASV titration (echocardiogram required)
- ❑ 95807 PAP Nap – Daytime trial of PAP to acclimate to therapy
- ❑ 95810/95805 PSG + MSLT or/ MWT – Day study following PSG for excessive sleepiness or screening for narcolepsy or/ measure alertness
- ❑ Other_____(Please specify)
- ❑ Special Instructions (i.e. **PSG Only**, O_2, Oral Appliance) _____

PRIMARY SYMPTOMS

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

ASSOCIATED CONDITIONS

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

MEDICAL DIAGNOSIS

For medical necessity, please check all that apply:

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

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.