

**SLEEP STUDY
REFERRAL**
Phone: 210-826-4000
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Toll Free: 877-223-1404
www.onirosleeplab.com



Patient Information

Patient's Name: _____ Date of Birth: _____ SS# _____

Patient's Phone# _____ Work# _____

Ordering Physician

Name: _____ Phone# _____ Fax# _____

Address: _____ City: _____ Zip Code: _____

NPI# _____ Tax ID# _____

Indication for Study (Please Check One):

- Obstructive Sleep Apnea (327.23) Hypersomnia with Sleep Apnea (780.53)
 Sleep Disturbance NOS (780.57) Narcolepsy (347.00)

Sleep Study Type (Please Check One)

- Diagnostic (First Night); Therapeutic (Second Night) if clinically indicated; Split Night (if patient AHI > 40/hr)
 MSLT - Multiple Sleep Latency Test (Testing for Narcolepsy)
 Home Sleep Test (95806)
 Pap-Nap, Daytime Study
 Other _____

Symptoms (Please circle all that apply):

- | | | | | |
|--------------|-----------------|------------------------------|---------|------------|
| Snoring | Gasping/Choking | Restlessness | Fatigue | Headaches |
| Irritability | Hypertension | Excessive Daytime Sleepiness | | Depression |

Letter of Medical Necessity: I undersigned; certify that the above prescribed procedure is medically necessary in the documentation and/or treatment of a sleep disorder.

- Yes No Is the patient currently on oxygen therapy?
 Yes No Does the patient have high blood pressure?

Doctor's Signature: _____ Date Signed: _____

Please Include: Copy of Insurance and Patient Demographics