Sleep & Research Centers of Southern California

(949) 770-0600 phone ♦ (877) 734-0309 fax

Sleep Study Referral Form

Referring Physician:

Physician Name	Phone#
Address	Fax#
City, State, Zip	NPI# UPIN#
Dr's Signature	Date of Order

Requested Sleep Study:

- ☐ Diagnostic Polysomnogram- CPT 95810
- ☐ Split Night Polysomnogram – CPT 95811
- ☐ Post-Operative Study for OSA- CPT 95810
- ☐ CPAP Titration Study – CPT 95811
- ☐ MSLT-CPT 95805
- ☐ Other:_____

Indications For Test: (Please check at least one, and all that apply)

☐ Witnessed Apnea ☐ Snoring ☐ Excessive Sleepiness ☐ Gasping/Choking ☐ Morning Headaches ☐ Insomnia
☐ Impaired Cognition ☐ Mood Disorders ☐ Coronary Artery Disease ☐ Noctrunal Arousals ☐ Hypertension
☐ Diabetes ☐ Weight Gain> 10lb/yr ☐ Neck Size > 17" ☐ History of Stroke ☐ Restless Leg

PLEASE COMPLETE THE QUESTIONS BELOW TO EXPEDITE SCHEDULING, thank you.

Previous Study: Yes/No When: __/__/__ Where:_____ Previous CPAP: Yes/No Current CPAP: Yes/No
Does patient use oxygen? Yes/No O2 Flow:_____lpm Does patient have a caregiver? Yes/No

Patient Information:

Last Name First Name	Home Phone #
Address	Work Phone #
City, State, Zip	DOB:
Primary Insurance:	Member ID #
☐ HMO ☐ MCARE ☐ EPO ☐ PPO ☐ MCAL ☐ Medi Medi	
Secondary Insurance:	Member ID#
☐ HMO ☐ MCARE ☐ EPO ☐ PPO ☐ MCAL ☐ Medi Medi	

Please fax with this order: Insurance Cards (front and back), any relevant patient history and clinical notes.
We will verify insurance and schedule the patient. Thank you

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24012 Calle de la Plata, Suite 350 Laguna Hills, CA 92653