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Referral for Obstructive Sleep Apnea Testing

Patient Name: _____
DOB: _____
Phone: _____
Email: _____
Insurance Provider: _____
Insurance Policy Number: _____
Insurance Phone Number: _____
Insurance Group ID: _____

Referring Physician Information: _____
License: _____
NPI: _____
Phone: _____
Email: _____
Office Name: _____
Office Tax ID: _____
Group NPI: _____

History and Symptoms

Please mark any that apply to patient

- Snoring R06.83
- Witnessed Apnea R06.81
- Morning Headaches R51.9
- Nocturia R35.1
- Daytime Sleepiness R40.0
- Fatigue R53.83
- Congestive Heart Failure 150.22
- Atrial Fibrillation I48.91
- Nocturnal Awakenings G47.23
- Impaired Cognition G31.84
- Sexual Dysfunction R37
- COPD J441
- Anxiety/Depression
- Other Symptoms:_____
_____

- Diabetes
- Insomnia G47.00
- Bruxism G47.63
- Hypertension I10
- Obesity (BMI: _____) Z68._ _
- Periodic limb movement disorder G47.61
- Restless Leg Syndrome G25.81
- Hypersomnia G47.11, G47.08, R53.83 G47.10
- Hypersomnia w depression F51.12 F51.19
- Upper Airway Resistance G47.8
- Other breathing abnormalities R0689
- Needs Re-Titration for OSA
- Obstructive Sleep Apnea G47.33
- Other Sleep Apnea R0689

Other Information: _____