Please complete form entirely

SLEEP INSTITUTE of NEW ENGLAND

Sleep and Pulmonary Referral Form

Patient Information:

Name: _____ DOB: _____ M/F: _____

Address: _____ Town/State: _____Zip code: _____

Phone: _____ Ht: _____ Wt: _____Neck size: _____ ESS: _____

Insurance Information: NO MEDICAID PLANS

Insurance Provider: _____ _____ID Number: _____

Insurance Auth #: _____ Referral Start Date: _____ End Date: _____ #Visits: _____

Referring Provider:

Requesting Physician: _____ Phone: _____ Fax: _____

Primary Care Physician: _____Phone: _____ Fax: _____

***ICD 10 codes/description:** _____

Service Requested:

Office notes, recent labs, imaging and any previous sleep studies MUST accompany ALL referral forms.

___ **Full Consult:** Includes consult, testing, homecare needs and follow up care

Testing Only: Referring physician provides the patient with results and follow up care.

___ 95810/95811: 2 Nights PSG: 1st night diagnostic study, 2nd night CPAP titration if indicated
___ 95810: 1 Night Polysomnography; diagnostic study only
___ 95811: CPAP Titration; diagnostic criteria from previous sleep study must be included
___ 95805: Multiple Sleep Latency Test (MSLT)
___ G0399: Home Sleep Test
___ G0399: DOT Home Sleep Test (ID bracelet is needed)
___ Complete PFT with Ambulatory Oximetry ___ PFT without Ambulatory Oximetry

**********Please obtain Prior Authorization from insurance company if referring for testing only **********

Referring Physician Signature: _____ Date: _____

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