



FACSIMILE TRANSMITTAL SHEET

TO:	PHYSICIAN OFFICE:
COMPANY: San Leandro Sleep Center	DATE:
FAX NUMBER: 1-510-614-7738	TOTAL NO. OF PAGES INCLUDING COVER:
PHONE NUMBER: 1-510-614-7728	SENDER'S REFERENCE NUMBER:

Documents Include:

- _____ Sleep Order Form (signed by the physician)
- _____ Demographics Sheet
- _____ Chart Notes during the patient's visit
- _____ Copy of Insurance Card
- _____ Pre-Authorization letter (if applicable)

- _____ Sleep Questionnaire

Please have the patient fill out the page below CLEARLY.

Name: _____

Cell Number: _____

Home Tel: _____

Work Tel: _____

Alternate Contact: _____

Tel. Number of Alternate Contact: _____

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San Leandro Sleep Disorders Center

13939 East 14th Street, Suite 180, San Leandro, CA 94578 Office 510-614-7728 Fax 510-614-7738 www.slsleep.com

Physician's Prescription

*Please fax the patient's CHART NOTES, DEMOGRAPHICS and INSURANCE INFO along with this prescription to **510-614-7738**.*

Patient Name (Printed): _____ Date of Birth: _____

Patient Phone: _____ Mobile/Alternate Phone: _____

Referring Physician: _____ CC: _____

PSG Study Date: _____ CPAP Study Date: _____

Procedure Order:

- NPSG (Diagnostic sleep study) 95810
- CPAP Titration only 95811
- NPSG w/ CPAP titration (if indicated) 95810 & 95811
- Bi-Level Titration only 95811
- NPSG followed by MSLT 95810 & 95805
- Split Night NPSG (PSG/CPAP) 95811

Clinical Symptoms:

Please check ALL symptoms that describe the patient's sleep complaint(s) (*One of these symptoms needs to be marked for a patient who has an AHI between 5 and 14 to qualify for home CPAP).

- *Excessive Daytime Sleepiness
- *Insomnia
- Witnessed Apnea
- Restless Legs
- *Impaired Cognition
- *Mood Disorders
- Snoring

Health History:

- *Hypertension
- Other Cardio Vascular Disease
- *History of Stroke
- *Ischemic Heart Disease
- Heart Failure / History of Heart Attack
- Depression
- Abnormal Oropharyngeal Exam
- Pulmonary Disease
- Diabetes
- BMI > 35 (Morbid Obesity)

Special Notes/Instructions: _____

Oxygen Wheelchair Care Giver/Aide Required Shift Worker (time: _____)

Ordering Physician Signature _____ **Date** _____

I have referred the above patient for a sleep diagnostic study for the reasons indicated on this form. I am aware that this patient may require two sleep studies and will be scheduled for the second study according to written protocol.

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