FACSIMILE TRANSMITTAL SHEET

TO: PHYSICIAN OFFICE:

COMPANY: DATE:
San Leandro Sleep Center

FAX NUMBER: TOTAL NO. OF PAGES INCLUDING COVER:
1-510-614-7738

PHONE NUMBER: SENDER’S REFERENCE NUMBER:
1-510-614-7728

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 Questionaire

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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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

_____ Ischemic Heart Disease

_____ History of Stroke

_____ History of Stroke

_____ Other Cardio Vascular Disease

_____ Hypertension

_____ Ischemic Heart Disease

_____ History of Stroke

_____ ABN 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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