Sleep Disorders Center
San Leandro

FACSIMILE TRANSMITTAL SHEET

TO:	**PHYSICAN 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 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: _____

13939 East 14th Street, Suite 180, San Leandro, CA 94578
Tel. 510-614-7728 Fax. 510-614-7738

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

_____ **NPSG w/ CPAP titration (if indicated) 95810 & 95811**

_____ NPSG followed by **MSLT 95810 & 95805**

_____ CPAP Titration only 95811

_____ Bi-Level Titration only 95811

_____ 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**

_____ ***Ischemic Heart Disease**

_____ Abnormal Oropharyngeal Exam

_____ Other Cardio Vascular Disease

_____ Heart Failure / History of Heart Attack

_____ Pulmonary Disease

_____ ***History of Stroke**

_____ Depression

_____ 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.