Wakefield Medical Inc.
SPECIALTY SERVICES

SLEEP REFERRAL FORM

120 Capcom Avenue Suite 102
Wake Forest, NC 27587
Phone: (919) 570-8277
Fax: (919) 570-8377

Patient Demographics

Please Print

Patient's Name: _____ Sex: M F Date of Birth: _____/_____/_____
(Last) (First) (M.I.)

Address: _____ Phone: (_____) _____ (Home)

_____ (_____) _____ (Work)

_____ (_____) _____ (Cell)

Insurance: ☐ Medicare ☐ Medicaid ☐ BCBS ☐ UHC ☐ Aetna

Other: _____

Referring MD: _____ Phone: (_____) _____

_____ Fax: (_____) _____

Polysmonogram Study Order

☐ Diagnostic Sleep Study (95810)
☐ Titration-CPAP or BIPAP (please circle one) (95811)
☐ Multiple Sleep Latency Test (MSLT) (95805)
☐ Split Night Study (per protocol) (95811)
☐ Overnight Pulse Oximetry (OPO) (94762)
☐ Sleep Screening (Free just for diagnosis)
☐ Overnight Sleep Study

Sleep Services

☐ **Evaluation & Treatment (included with this service)**

We will evaluate and manage patient's sleep diagnosis and therapy needs

- Prescreening and consultation visit with our sleep physician
- Recommend testing based on a consultation visit
- Post follow-up visit after sleep studies to go over findings and treatment options
- Equipment setup if needed for treatment (CPAP, BIPAP, Dental Appliance and supplies)
- Ongoing management of sleep therapy and care

History and Physical Examination

Referring MD to complete

SECTION A: Specific History (Check all appropriate diagnosis):
☐ Obstructive Sleep Apnea (327.23)
☐ Documented unexplained sleep-related oxygen desaturation

SECTION B: Other Indications
☐ Narcolepsy (347.00)
☐ Memory Impairment (780.93)
☐ Obesity (278.00)
☐ Hypertension (401.9)
☐ Insomnia (780.52)
☐ Daytime Fatigue (780.79)
☐ Stroke (436)
☐ Congestive Heart Failure (428.0)
☐ Periodic Limb Movement (327.51)
☐ Restless Leg Syndrome (333.94)

Face to Face Date: _____ **Epworth** _____

☑ Patient Demographics/Face Sheet
☑ Copy (front and back) of Insurance Cards
☑ Current Medication List
☑ History & Physical
☑ Medical Records including Face-to-Face Notes

Current Medications

Sleep Medicine Use: ☐ Yes Name of Drug: _____ Other Medications: _____

Allergies: ☐ None ☐ Yes (Specify): _____

Special Instructions/Special Needs: _____

Oxygen Requirements: Flow _____ LPM O2 Stat _____% ☐ Continuous ☐ PRN

Letter of Medical Necessity

I have referred the above named patient for a medically necessary 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 which states that if the RDI for the first study is > 20, then the second study will be performed to titrate CPAP to the appropriate pressure.

Physician's Signature: _____ Date: _____