

Phone: 214-750-7776

Fax: 214-739-1656

REFERRING PHYSICIAN INFORMATION	
Referring Physician's Name	Specialty
Street Address	Phone Number <span style="float: right;">Fax Number</span>
City, State, Zip	NPI #
PATIENT INFORMATION	
Patient's Name <span style="float: right;">DOB</span>	Address
Home Phone <span style="float: right;">Cell Phone</span> <span style="float: right;">Work Phone</span>	City, State, Zip
Email Address	Person Completing Order
INSURANCE INFORMATION	
Insurance Provider [Product] HMO PPO POS EPO Indem MCR MCD	Benefits Phone Number
Policy Number <span style="float: right;">Group Number</span>	Insured [Self Sp Child Other] <span style="float: right;">Employer</span>
REASON FOR REFERRAL <b>mark ALL that apply</b>	
<input type="checkbox"/> G47.33 OSA - witnessed breathing pauses during sleep <input type="checkbox"/> G47.10 Hypersomnia, Unspecified (EDS) <input type="checkbox"/> F51.3 Sleep Arousals <input type="checkbox"/> R06.83 Respiratory Insufficiency (Disruptive Snoring) <input type="checkbox"/> G47.61 Periodic Limb Movements during sleep	<input type="checkbox"/> R53.83 Fatigue <input type="checkbox"/> E66.9 Obesity <input type="checkbox"/> G25.81 Restless Legs <input type="checkbox"/> G47.26 Shift Work Disorder <input type="checkbox"/> G47.00 Insomnia, Unspecified <input type="checkbox"/> G47.419 Narcolepsy
Previous Sleep Study: <input type="checkbox"/> Yes <input type="checkbox"/> No When: _____ Currently on CPAP: <input type="checkbox"/> Yes <input type="checkbox"/> No Since When: _____ Pressure: _____	
Does patient have/need: <input type="checkbox"/> Oxygen <input type="checkbox"/> Insulin <input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> Cardiac/Antihypertensive medications <input type="checkbox"/> Antidepressant medications	
REFERRAL OPTIONS	
I <input type="checkbox"/> <b>EVAL, DIAGNOSE, TREAT</b> - Sleep Specialist to diagnose and manage patient's sleep disorder <div style="text-align: center; margin-top: 5px;"> <b>ANY</b>      Dr. Becker      Dr. Jamieson      Dr. Rosenthal      Dr. Stevenson           </div>	
II <input type="checkbox"/> <b>HOME SLEEP TEST (HST) * for sleep apnea</b> <input type="checkbox"/> HST + Eval <input type="checkbox"/> HST Only	
III <input type="checkbox"/> <b>DIRECT SLEEP STUDY</b> <input type="checkbox"/> Diagnostic Study + Eval <input type="checkbox"/> Diagnostic Study <b>Only</b> <input type="checkbox"/> Diagnostic Study + CPAP Study (2 nights of study if necessary) <input type="checkbox"/> Split night of DX & CPAP study (Must meet criteria) <input type="checkbox"/> CPAP Study <b>Only</b>	
IV <input type="checkbox"/> <b>OTHER SERVICES</b> <input type="checkbox"/> Oral Appliance Therapy <input type="checkbox"/> Home Pulse Oximetry	
<b>Ordering Physician's signature:</b>	<b>Date:</b>

**Dallas - 1 block N PHD**  
 5477 Glen Lakes Dr 100  
 Dallas, TX 75231

**Plano - 1 Block N BHP**  
 4712 Dexter Dr. 200  
 Plano, TX 75093

**Allen - PHA MOB II**  
 1105 N Central Expy 2305  
 Allen, TX 75013

***Please send clinicals for all services ordered & we will obtain precerts***