SLEEP MEDICINE

VALLEY VIEW HOSPITAL

1906 BLAKE AVE GLENWOOD SPRINGS, CO 81601

PHONE: 970-384-7694 FAX: 970-384-4202

SLEEP STUDY REFERRAL FORM

Please fax a copy of insurance card, patient demographics, overnight pulse oximetry results and provider notes to 970-384-4202.

PATIENT'S LAST NAME _____ FIRST NAME _____

BIRTH DATE: PHONE: ( )

1. OVERNIGHT SLEEP STUDY REQUEST:

- ☐ HOME SLEEP STUDY (CPT- 95806; G0399) ☐ TWO NIGHT HST ☐ ONE NIGHT HST
- ☐ DIAGNOSTIC POLYSOMNOGRAM ONLY (CPT- 95810) ☐ PEDIATRIC POLYSOMNOGRAM (CPT-95810 OR 95782 IF < 6 YRS
- ☐ SPLIT NIGHT POLYSOMNOGRAM (PSG) WITH CPAP/BI-LEVEL/ASV TITRATION, IF CRITERIA MET. (CPT-95811)
- ☐ TITRATION STUDY ONLY- CPAP/BI-LEVEL/ BI-LEVEL ST / ASV (CPT-95811)
- ☐ ALTITUDE TESTING-IF PATIENT LIVES AT AN ALTITUDE OF 7000 FEET OR ABOVE.
- ☐ MSLT (MULTIPLE SLEEP LATENCY TEST) FOR PATIENTS WITH SUSPECTED NARCOLEPSY/ IDIOPATHIC HYPERSOMNIA (CPT-95805) (SHOULD BE SCHEDULED AFTER A PSG ON THE PREVIOUS NIGHT

PLEASE PRESCRIBE A SLEEP-AID FOR THE PATIENT TO SELF-ADMINISTER ON THE NIGHT OF THE STUDY SHOULD THEY HAVE DIFFICULTY SLEEPING. IE: ESZOPICLONE OR ZOLPIDEM .

REASON FOR STUDY:

- ☐ OBSTRUCTIVE SLEEP APNEA (G47.33) ☐ HYPERSOMNIA, UNSPECIFIED (G47.10)
- ☐ SLEEP APNEA, UNSPECIFIED (G47.30) ☐ PRIMARY CENTRAL SLEEP APNEA (G47.31)
- ☐ SLEEP RELATED HYPOVENTILATION (G47.36) ☐ OTHER _____

PHYSICIAN SIGNATURE:_____ DATE:_____
PHYSICIAN NAME (PRINT):_____
OFFICE PHONE:_____ OFFICE FAX:_____

WE WILL VERIFY INSURANCE COVERAGE AND OBTAIN PRIOR AUTHORIZATION BEFORE CONTACTING PATIENT TO SCHEDULE STUDY.

THANK YOU FOR YOUR REFERRAL.