Sleep Medicine Specialists of california

SLEEP EVALUATION REQUEST

Referral to Dr. Haramandeep Singh (NPI 1154410967) & Dr. Navjot Grewal (NPI 1245646231)

Patient Name: FIRST_____MI_____LAST_____

Date of Birth: _____/_____/_____ Phone: (H)_____(W)_____(C)_____

{CHECK ALL ORDERS THAT APPLY}

_____ **Consult/Management –** Please evaluate and manage sleep issues prior to and/or post test(s).

_____ **Diagnostic, Comprehensive Polysomnography**

_____ **CPAP/Bi-Level PAP/ASV/Oral Appliance Titration Polysomnogram**

_____ **Split Night Polysomnography** – Diagnostic portion followed by titration portion

_____ **Multiple Sleep Latency Test (MSLT)/Maintenance of Wakefulness Test (MWT)** [Daytime tests]

_____ **Home Sleep Test** [Unattended home sleep test.]

PLEASE FAX THIS FORM TO *(888) 850-1210* WITH THE FOLLOWING:

1. **Copy of insurance card** and **demographic info**
2. **Clinical notes related to sleep issues**

PRELIMINARY DIAGNOSIS CODES

_____Sleep Apnea/Sleep Related Breathing Disorder, Unspecified (ICD-10 G47.30)
_____Obstructive Sleep Apnea (ICD-10 G47.33) _____Hypersomnia (ICD-10 G47.10)
_____Periodic Limb Movements (ICD-10 G47.61) Other:_____

Clinical presentation/symptoms/existing illnesses (notation not needed if clinical notes faxed):

_____

_____

_____Oxygen to be titrated as needed _____Patient to self-administer own medicine
Other instructions:_____

ORDERING PROVIDER INFORMATION

Provider Name:_____ Office Contact:_____
Phone:_____ Fax:_____

PROVIDER SIGNATURE:

_____**DATE:** _____

I certify that to the best of my knowledge, this test and any interpretation is medically necessary in order to assist in the proper diagnosis and/or treatment for the above named patient.