

Prescription- Please fax



THE SLEEP INSTITUTE OF UTAH
"Professional Sleep Solutions"

PEDIATRIC SLEEP STUDY REFERRAL FORM

South Ogden

Layton

Murray

South Jordan

Orem

Tooele

Date Ordered _____

Patient _____ Parent/Guardian _____

Address _____ City _____ Zip _____

Daytime Phone _____ Evening Phone _____

D.O.B. _____ S.S.# _____

Insured Name _____ Insured S.S.# _____

Primary Insurance _____ Policy# _____

- **Please fax current history and physical**

Please check if you would like a consultation prior to procedure

Diagnosis: (Please check all that apply.)

Apnea 327.23

Unexplained drowsiness 780.54

Periodic limb movement disorder 327.51

Sleep disturbance 780.50

Insomnia 780.52

Narcolepsy 347.00

Restless leg 333.99

Other reason for study _____

List signs/symptoms

Procedures: (Please check.)

Baseline 95810

CPAP/BIPAP 95811

Multiple Latency Test (MSLT) 95805 - always combined with (95810)

Special Procedure/Request _____

Does the patient use CPAP/BIPAP? Yes No If yes, pressure and mask size _____

DME Company _____

Oxygen Protocol: Oxygen will be added if the SpO2 falls below 85% for greater than five minutes.

Please provide a cell number or answering service where someone from your office can be reached should any questions arise during the study. _____

Clinic _____ Physician _____

Physician Phone _____ Physician Fax _____

Physician Signature _____ Date _____

Contact Person _____