4 BETTER SLEEP CENTERS
(214) 466-7222

REFERRAL FORM (Certificate of Medical Necessity)

Please fax to (214) 466-7220

1. PATIENT

(Last) (First) (MI)

(Street address) (City) (State) (Zip code)

DOB / / DL # SSN# SEX: M / F

PHONE: (Home) (Work): (Cell):

INSURANCE: Policy #

PLEASE INCLUDE A COPY OF THE PATIENT'S INSURANCE CARD (FRONT & BACK)

2. SERVICES:

___ **Evaluate and Treat** (Evaluation of patient's complaints and coordination of care)
___ **PAP Supplies/machine** (Mask, hose, filters and/or full set-up)
___ **Home Testing** (For use in patient's home overnight)
___ **NPSG & CPAP titration** (Full night of NPSG followed by a full night of PAP Therapy as indicated)
___ **Split study** (Single night NPSG and PAP Therapy combined – depends on meeting certain criteria)
___ **Overnight Oximetry** (For use in patient's home overnight – oxygen levels only)
___ **EEG** (Ambulatory video electroencephalogram)
___ **Other**_____

3. DIAGNOSIS:

___ Obstructive Sleep Apnea ___ Other_____

4. CO-MORBIDITIES:

___ BMI≥35 plus inability to lie flat in bed)
___ Hypertension
___ Heart Disease
___ Stroke
___ Diabetes
___ Other_____
___ Pulmonary Disease
___ Neuromuscular Disease

5. CLINICAL SYMPTOMS:

___ STOP BANG score _____
___ Excessive Daytime Sleepiness
___ Impaired Concentration
___ Difficulty Initiating/Maintaining Sleep
___ Snoring
___ Hypersomnia
___ Respiratory Disorder
___ Other_____
___ Witnessed Apnea
___ Seizure/Syncope
___ Limb Movements

6. PHYSICIAN NAME: *COMPLETED BY:

PHYSICIAN SIGNATURE:

ADDRESS:

***PHONE:** FAX:

NPI: SPECIAL INSTRUCTIONS/REMARKS:

Dallas Office	Heath/Rockwall Office
8722 Greenville Ave. Suite 102 Dallas, TX 75243	6435 S. FM 549 Suite 202 Heath, TX 75032