4 BETTER SLEEP CENTERS
(214) 466-7222

REFERRAL FORM (Certificate of Medical Necessity)

Please fax to (214) 466-7220 or (888) 613-0387

1. PATIENT

(Last) (First) (MI)

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

DOB / / SEX: M / F

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

INSURANCE: Policy #

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

2. SERVICES

___ **Specialist Consult** (Evaluation of patient's complaints – PLEASE INCLUDE ANY IMAGING & CLINICALS)
___ **Home Testing**
___ **NPSG/CPAP Titration**
___ **NPSG Only**
___ **CPAP titration only**
___ **SPLIT Study**
___ **NPSG/MSLT** (Full night of polysomnography followed by a Multiple Sleep Latency Test)
___ **MWT** (Maintenance of Wakefulness Test)
___ **CPAP Machine**
___ **CPAP Supplies**
___ **Oral Appliance** (Mandibular Advancement Device)
___ **EEG** (Ambulatory video electroencephalogram)

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	PLANO OFFICE
8722 Greenville Ave. Suite 102 Dallas, TX 75243	6435 S FM 549 Suite 202 Heath, TX 75032	6205 Chapel Hill Blvd Suite 400 Plano, TX 75093