Ballantyne Diagnostic & Sleep Center

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SLEEP REFERRAL REQUEST

*Please **complete items 1-5 below and fax 704.752.7557** Or you may call us at 704.943.5075 to schedule the appointment immediately.*

(1.) Patient Information

Patient Name: _____ M / F Date of Birth: _____
Phone Numbers Home: _____ Cell: _____ Work: _____
Insurance Company: __FAX COPIES_____

WE VERIFY & GET AUTHORIZATIONS ON PATIENT'S INSURANCE, THERFORE WE NEED PATIENT DEMOS & COPY OF INSURANCE CARD FAXED WITH THIS FORM

(2.) Type of Sleep Referral

- ❑ **Evaluate & Treat**
- ❑ **Sleep Study ONLY** (one night)
- ❑ **Sleep Study & CPAP Study** (if 1st study meet qualifications for CPAP study)
- ❑ **CPAP Trial/** Re-Titration study
- ❑ **Home Testing/** if meets protocol for insurance coverage
- ❑ **Split Study** if AHI>_____ OR meets protocol per insurance plan
- ❑ **Day Study** (Circle Test) MSLT (Multiple Sleep Latency) or MWT (Maintenance of Wakefulness)

SPECIAL INSTRUCTIONS: _____

(3.) Follow-up

- ❑ Patient follows up with ***ordering/referring*** physician
- ❑ Patient follows up with ***sleep physician*** or other: _____

(4.) Reason for Sleep Appointment or Sleep Study

Chief Complaint(s): _____

OR Dx Code(s): _____

(5.) Physician Sleep Prescription

Referring Office: _____ Referring Physician (print): _____

Scheduler Name: _____ Phone: _____ Fax: _____

Referring Physician Signature: _____

WE WILL FAX THIS FORM BACK TO YOUR OFFICE WHEN THE PATIENT HAS SCHEDULED THE SLEEP STUDY WITH US

Appointment Scheduled

TYPE APPOINTMENT _____ **DATE** _____