Ballantyne Diagnostic & Sleep Center

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SLEEP STUDY REFERRAL REQUEST

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

(1.) Patient Information

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

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

(2.) Type of Study to be performed:

- **PSG & Follow-up w/CPAP** trial if AHI >10
- **PSG** only
- **Evaluate & Treat** (sleep physician consult)
- **CPAP Trial**/ Re-Titration study
- **Home Testing**/ Apnea Screening, if AHI>10, CPAP Titrate & treat
- **Split Study** if AHI>20
- **Day Study,** Circle one- MSLT or MWT
- **Inspire Qualification Study**
- **Inspire Activation**
- **Inspire Fine Tune Study**

SPECIAL INSTRUCTIONS: _____

(3.) Reason for Study

Chief Complaint(s) **OR** Dx Code(s): _____

(4.) Follow-up

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

(5.) Physician Sleep Prescription

Referring Physician (print): _____ ***Signature***: _____

Phone Number: _____ Fax: _____

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

Appointment Scheduled

Date: _____ **Time:** _____