White Plains Hospital

The Sleep Diagnostic Center
at White Plains Hospital
Davis Ave. and E. Post Rd., White Plains, NY 10601
Phone: 914-681-2626 **Fax: 914-750-7425**

SLEEP STUDY PRESCRIPTION REFERRAL FORM

PATIENT INFO:

Name:____ DOB:_____/_____/______ Date:_____/_____/______

Phone:_________________________ Cell:________________________ Other:________________________ ☐ M ☐ F

Address:____ City:__________________ St:____ Zip:___________

Email Address: ____

INSURANCE INFO: *Please submit a photocopy of the patient's insurance card (FRONT AND BACK)*

Primary Insurance Carrier: ____ Policy/ID#: ___________________________

Second Insurance Carrier: ____ Policy/ID#: ___________________________

Insured Name: ________________________________ Insured DOB: _____/_____/______ Relationship: _______________

PHYSICIAN INFO:

Requesting MD: _________________________________ Tel: _______________________ Fax: ________________________

Requesting NPI#: _________________________ Specialty: ____

Primary Care MD: ________________________________Tel: _______________________ Fax:________________________

TEST REQUESTED: *(Check Applicable)*

☐ **I request a consult with sleep specialist** ☐ **before** ☐ **after sleep study with:** ___Dr. Fulvia Milite ___No Preference

☐ Comprehensive: PSG (95810) & follow-up PAP Titration (95811) if PSG is positive, AHI>5, I authorize PAP titration

☐ Polysomnography (PSG) (95810)

☐ Split-Night study (1/2-PSG, 1/2-CPAP Titration (95811)

☐ PSG w/Multiple Sleep Latency Test (MSLT) (95805)

☐ PSG w/Maintenance of Wakefulness Test (MWT) (95805)

☐ CPAP Titration (95811)

☐ PAP NAP (95807-52)

☐ HST (Home Sleep Test) (95806)

INDICATIONS: *(Check Applicable)*

☐ Snoring (R06.83)
☐ Witnessed Apnea (G47.30)
☐ Daytime Sleepiness (G47.10)
☐ Shortness of Breath (R06.00)
☐ Obstructive Sleep Apnea (G47.33)

☐ Morbid Obesity (E66.01)
☐ High Blood Pressure (I10)
☐ Arrhythmia (I49.9)
☐ Chronic Lung Disease (J44.9)
☐ OTHER: ____

☐ Limb Movement Disorder (G47.61)
☐ Narcolepsy (G47.419)
☐ Post-Op ENT Surgery (DATE:_____________)
☐ Pre-Bariatric Surgery

SPECIAL NEEDS: *(Check Applicable)*

☐ **Currently on PAP/BIPAP?** ☐ NO ☐ YES________cmH2O

☐ **Currently Using Supplemental Oxygen**: ___________ L/min Use for testing? ☐ NO ☐ YES

☐ Tape, latex, talc allergy ☐ Incontinence ☐ Walker

☐ Wheelchair ☐ Translator (Language: __________________________)

☐ Other____

MEDICAL HISTORY: ***You MUST attach a copy of patient's most recent History and Physical.***

I AUTHORIZE SLEEP CENTER TO PERFORM SLEEP STUDY ON ABOVE PATIENT ACCORDING TO THEIR PROTOCOLS, INCLUDING URGENT INITIATION OF OXYGEN & CPAP. IF AN IN-LAB STUDY IS ORDERED BUT DENIED BY INSURANCE, I APPROVE A HOME SLEEP APNEA TEST INSTEAD.

I certify: That this service is medically necessary. The information provided is true, accurate and documented in the patient's clinical notes.

Physician Signature: ____ Date:_________________