Daviess Community Hospital
An Affiliate of Ascension St. Vincent

DCH Sleep Disorders Center Referral Form

Patient name: _____ **BMI:** _____

Date of birth: _____ **Phone number:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Test date: _____ **Test time:** _____

Insurance: _____ **Group number:** _____

Prior authorization: _____ **Diagnosis Code:** _____

☐ Diagnostic PSG (95810) ☐ Home Sleep Study (95806) ☐ Titration Study w/CPAP (95811) ☐ Split night (95811)

Medical Necessity for Sleep Test: *(Mark as many as applies. 4 or more desired. **At least 2 required.**)*

- ☐ Snoring
- ☐ Observed apneas
- ☐ Awakens choking/gasping
- ☐ Morning headaches
- ☐ Nocturnal urination, frequent
- ☐ Screen using home sleep test if high probability of OSA
- ☐ Patient needs a CPAP titration – had a diagnostic PSG prior that was positive for OSA
- ☐ Past positive OSA dx
- ☐ Daytime Sleepiness, can be excessive
- ☐ Toss, turn, restless during sleep
- ☐ Lack freshness despite routine sleep
- ☐ Currently wear CPAP
- ☐ Hypertension

Medical History: *(Please circle **all** applicable conditions)*

☐ Migraines ☐ Seizures ☐ CHF ☐ Diabetes ☐ Bruxism ☐ Arrhythmia
☐ Restless Leg Syndrome ☐ Depression ☐ Stroke ☐ Obesity ☐ COPD ☐ Hypothyroidism

Epworth Sleepiness Score: *(**Required**)* _____/24

Anand Bhuptani, MD, ABSM, will be interpreting sleep test.

By signing below, I agree that upon my examination and evaluation of the patient, that included history and physical, including HEENT, CVS, Respiratory, CNS, and vital signs, there is a high probability of diagnosis of sleep apnea and diagnosis code of ICD 10: G47.33 will be used unless specified otherwise. (Other _____)

Ordering practitioner: _____ Phone: _____

Signature: _____ Date: _____

Please check insurance prior authorization. Fax this order, along with H&P and last office visit note to (812) 254-2953. For questions regarding scheduling, call (812) 254-9324. For Cardiopulmonary Services, call (812) 254-8883.