Sleep Disorders Prescription
Please fax to (877) 762-6745

SEQUOIA SLEEP DIAGNOSTICS
7575 N. Cedar Ave., Ste. 103 Fresno, CA 93720
Phone: 559.981.5144 Fax: 559.981.5155

PATIENT NAME:_____ **DOB:** _____ **SS#**_____
Last **First** **MI**
ADDRESS:_____**City:**_____**State:**_____**Zip:**_____

HOME:_____ **CELL:** _____**WORK:**_____

Height: _____ **Weight:** _____ **Neck Circumference:**_____ **Oxygen Use (Y/N):** _____ **LPM:** _____ **Sex: (M/F):** _____

INSURANCE: Policyholder ID#_____ **Group #**_____

□ **Medicare** □ **Work Comp** □**PPO: Name of Ins. Co.**_____ **Auth#**_____

Please attach patient's clinical history, medications, physician's notes, demographics, & insurance information

SYMPTOMS & REASON FOR REFERRAL

☐ **Witnessed Apneas**	☐ **Obesity (BMI_____)**	☐ **Ischemic Heart Disease**	☐ **COPD**
☐ **Excessive Daytime Sleepiness**	☐ **Periodic limb movements**	☐ **Hypertension**	☐ **CHF**
☐ **Choking/Gasping in Sleep**	☐ **Obstructive sleep apnea**	☐ **History of stroke**	☐ **Seizures**
☐ **Sleep apnea, unspecified**	☐ **Central sleep apnea**	☐ **Bariatric Surgery To Follow**	☐ **Insomnia**
☐ **Sleep disorder, unspecified**	☐ _____	☐ _____	☐ _____

SLEEP DISORDERS DIAGNOSTIC SERVICES
Please attach any previous diagnostic sleep test

☐ **Sleep Consultation** by Board Certified Physician/Sleep Specialist

☐ **PSG:** Full night in lab diagnostic polysomnography attended by a technologist. **(CPT 95810)** ☐ **with Oral Appliance**

☐ **Split Night PSG:** Full night in lab: first half diagnostic, second half with CPAP or Oral Appliance attended by a technologist. **(CPT 95811)**

☐ **Full PSG CPAP Titration:** Full night in lab polysomnography with CPAP attended by a technologist. **(CPT 95811)**

☐ **MSLT/MWT:** Multiple Sleep Latency Test/Multiple Wakefulness Test / Narcolepsy evaluation. Note: If patient meets diagnostic and procedural protocol, PAP titration will be performed and MSLT cancelled. **(CPT 95810 and 95811 or 95805)**

☐ **Unattended Sleep Study:** Home Sleep Study ☐ 3 three night Diagnostic Test **(CPT Code 95806, G0399)**

☐ **Special Requests:** _____

Referring Physician: _____ **NPI:** _____ **License:**_____
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Phone:_____ **Fax:**_____ **Email:**_____

I certify this patient has absolute medical necessity for the above diagnostic test based upon the suspected diagnosis of Sleep Disordered Breathing/Apnea. I certify this testing is medically indicated and is reasonable and necessary per the standards of medical practice and treatment of this patient. A faxed authorization is as valid as the original.

Physician Signature:_____ **Date:**_____