HeMacinto Sound Sleep Center

343 East Main Street, Suite 106
San Jacinto, CA 92583
Phone #: (951) 654-5592 Fax: (951) 654-0839

SLEEP STUDY REFERRAL FORM

Patient Name: _____ DOB: _____
Home Phone: _____ Work Phone: _____

Diagnosis_____

Referring Physician: _____ License: _____
Phone: _____ Fax: _____ UPIN: _____

□ Sleep Consultation (CPT 99242, 99244, 99213 or 99215)
□ Diagnostic Sleep Study (PSG) (CPT 95810)
CPAP titration if positive for OSA (CPT 95811)
□ Split night Sleep Study (PSG) (CPT 95811)
□ CPAP titration PSG (CPT 95811)
□ Home Sleep Test (CPT 95806)
□ Multiple Sleep Latency Test/Multiple wakefulness Test (MSLT/MWT)
(CPT 95810 and 95811 or 95805)
□ PAP-NAP (CPT 95807)
□ Overnight Oximetry (CPT 94762)
□ Special instructions:
_____
□ Treatment Authorization: Allow Sleep Physician to manage patient's sleep disorder by prescribing treatment and following patient

Physician's Signature: _____
Date: _____

Please fax the following to Hemacinto Sound Sleep Center:
1. Sleep study referral form
2. Patient's demographics and insurance information.
3. Patient's clinical history or physician notes, if applicable.

Fax: (951)654-0839
Any questions call Phone #: (951)654-5592