FusionSleep®
All We Do Is Sleep®

REFERRAL

Please fax with office notes and insurance card to:

678.840.3777

Accredited by AASM American Academy of SLEEP MEDICINE™

OFFICE TO COMPLETE

OFFICE CONTACT DETAILS

Practice Contact Name:	Practice Phone:	Practice Fax:

PATIENT PERSONAL INFORMATION

Last Name:	First Name:	◯ M / F ◯	DOB:

Primary Phone:	Alternate Phone:	Email Address:

Height:	Weight:	Neck Circumference:	B/P:	BMI:

PROVIDER TO COMPLETE / MEDICAL ORDERS

MEDICAL HISTORY:

- ☐ Hypertension
- ☐ Obesity BMI>30 kg/m2
- ☐ Sleep Apnea
- ☐ Diabetes
- ☐ Arrhythmias
- ☐ Neurologic disorder
- ☐ CHF
- ☐ Supplemental Oxygen
- ☐ Other - Please Specify:

Allergies:

Medications:

Additional Info:

PRESENTING SYMPTOMS:

- ☐ Preliminary Diagnosis: Obstructive Sleep Apnea (G47.33)
- ☐ Loud Snoring
- ☐ Excessive Daytime Sleepiness
- ☐ Witnessed Apnea
- ☐ Insomnia
- ☐ Periodic Leg Movements (PLMs)
- ☐ Restless During Sleep
- ☐ Nocturnal Seizures
- ☐ Impaired Cognition
- ☐ Awakens with Choking or Gasping
- ☐ Sleep Bruxism
- ☐ Parasomnias

MEDICAL ORDERS:

- ☐ **Consultation, Testing & Treatment** (As indicated by center physician)
- ☐ **PSG, Follow-up Consultation & Therapy Program, if positive (HSAT, if PSG is denied)**
- ☐ **Home Sleep Apnea Test (HSAT), Follow-up Consultation & Therapy Program, if positive**
- ☐ **APAP Device Set-up & Therapy Management Program**
  Prescribed Pressure: 6 - 20cm H2O or preferred settings here: _____
  THIS IS A STANDARD RECOMMENDATION & MAY NOT BE IDEAL FOR SOME PATIENTS.
- ☐ **Oral Appliance Therapy Program**

REFERRING PHYSICIAN TO REVIEW RESULTS & TREATMENT OPTIONS:

- ☐ **Home Sleep Apnea Test**
- ☐ **PSG (HSAT, if PSG is denied)**
- ☐ **Lab Split Study (HSAT, if Lab Split is denied)**
- ☐ **CPAP Titration** ☐ **BiPAP Titration**

PRINT PROVIDER NAME	DATE	PROVIDER SIGNATURE

Did you include the following information? This is VITAL for insurance verification and pre-certing.

☐ Patient Demographics ☐ Copy of Patient's Insurance Card ☐ Office/Medical Notes ☐ Lab Work (within last 6 mo.)
☐ If an insurance referral is required please attach when faxing.