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

| Parent/Guardian's Full Name: | Child's First Name: | Child's Last Name: | M / F | Child DOB: |
|---|---|---|---|---|
| Primary Phone: | Alternate Phone: | | Email Address: | |
| Height: | Weight: | Neck Circumference: | B/P: | BMI: |

## PROVIDER TO COMPLETE / MEDICAL ORDERS

### MEDICAL HISTORY:

- ☐ Premature Birth
- ☐ ICU or Monitoring
- ☐ Neurological Disorder
- ☐ Recurrent Otitus or Strep
- ☐ ADHD/ADD
- ☐ Obesity
- ☐ Developmental Delay
- ☐ Autism
- ☐ Epilepsy
- ☐ Adenoid/Tonsillar Hypertrophy
- ☐ Other - Please Specify:

### 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 Choking or Gasping
- ☐ Sleep Bruxism
- ☐ Parasomnias
- ☐ Cataplexy
- ☐ Enuresis

### MEDICAL ORDERS:

- ☐ **Consultation, Testing & Treatment** (As indicated by center physician)

  **Diagnostic Testing, Follow-up Consultation & Therapy Program, if positive**

### REFERRING PHYSICIAN TO REVIEW RESULTS & TREATMENT OPTIONS:

**PSG**

(Please send documentation of medical necessity)

- ☐ **1:1 Ratio Sleep Tech** (Special Needs Patient)
- ☐ **End - Tidal Carbon Dioxide Monitoring**

- ☐ **PSG with MSLT**
- ☐ **CPAP** (Please send documentation)
- ☐ **Allergies:**
- ☐ **Medications:**

| 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.
- ☐ Previous Sleep Study Results

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