Referral Form
Medical Necessity Certificate

SNI Sleep Center
Tel (214) 574 4999 • Fax (214) 496 0922
www.snisleepcenter.com

Gender: ○ Male ○ Female

Patient Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

Address 2: _____ Insurance Carrier: _____

City/State/Zip: _____ Insurance ID #: _____

Home Phone: _____ Insurance Group #: _____

Alt Phone: _____ Insurance Phone #: _____

SERVICE REQUESTED

☐ Polysomnography ☐ Maintenance of Wakefulness Test ☐ Split Study ☐ Home Sleep Test
☐ CPAP/BIPAP Titration ☐ Multiple Sleep Latency Test ☐ Consultation ☐ Medication Management
☐ CPAP Management ☐ Other _____

CLINICAL DIAGNOSIS

☐ Sleep Apnea ☐ Narcolepsy ☐ Periodic Limb Movement ☐ Other: _____

SIGNS & SYMPTOMS

Patient

☐ Awakening with Snore ☐ Gasping for Air ☐ Shortness of Breath ☐ Restless Sleep
☐ Unusual Movements ☐ Daytime Fatigue/ Sleepiness ☐ Limb Movements ☐ Limb Discomfort
☐ Nonrestorative Sleep ☐ Memory/ Attention Problems ☐ Frequent Headaches

Observer

☐ Snoring ☐ Apnea ☐ Gasps/ Snorts ☐ Restless Sleeper ☐ Excessive Sleepiness

Medical Condition

☐ Heart Disease ☐ Lung Disease ☐ Neuromuscular Disease
☐ Stroke ☐ Sleep Apnea ☐ High Blood Pressure

Referring Physician Statement:

I certify that I am referring the above named patient.
I certify that the above tests are medically necessary for the appropriate treatment of the above named patient.

Sleep Test Requested by:

_____
Physician name (Please Print)

_____
Signature

Date Requested: _____ / _____ / _____

PLEASE FAX THIS COMPLETED FORM WITH A COPY (FRONT & BACK) OF THE PATIENT'S INSURANCE CARD, SLEEP SURVEY AND CLINICAL NOTES TO: (214) 496 0922

SNI Sleep Center

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