Referral Form
Medical Necessity Certificate

Tel (214) 574 4999 • Fax (214) 496 0922
www.snineurosleep.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
- ☐ CPAP/BIPAP Titration
- ☐ Maintenance of Wakefulness Test
- ☐ Multiple Sleep Latency Test
- ☐ Split Study
- ☐ Consultation
- ☐ CPAP Management
- ☐ Home Sleep Test
- ☐ Medication Management
- ☐ Other ______________

CLINICAL DIAGNOSIS

- ☐ Sleep Apnea
- ☐ Narcolepsy
- ☐ Periodic Limb Movement
- ☐ Other: ________________________________

SIGNS & SYMPTOMS

Patient

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

Observer

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

Medical Condition

- ☐ Heart Disease
- ☐ Stroke
- ☐ Lung Disease
- ☐ Sleep Apnea
- ☐ Neuromuscular Disease
- ☐ 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.

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

Sleep Test Requested by:

____
Physician name (Please Print)

____
Signature

Date Requested: ________ / _________ / ________

(This part to be completed by the Sleep Center)

As a board-certified sleep specialist I have reviewed the clinic information on this patient and certify that this patient meets required standards for the procedure ordered.

____
Henry Raroque, Jr. MD, FAASM

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