Athens Pulmonary
3320 Old Jefferson Rd. Suite 200-A
Athens, GA 30607
706-549-4710
**(Fax) 706-549-5825**

# SLEEP STUDY REFERRAL FORM

## PATIENT DEMOGRAPHICS:

Last Name: _____ First Name:_____ Sex:_____ DOB: _____

Address: _____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____ Email: _____

## INSURANCE DEMOGRAPHICS:

Payer Name:_____ ID# :_____ Group #:_____ Phone#:_____

## REFERRING PHYSICIAN DEMOGRAPHICS:

Physician Name:_____ Phone #: _____ Fax#:_____

Address:_____ City:_____ State:_____ Zip:_____

**SYMPTOMS / INDICATIONS FOR TESTING:** (*Check all that apply*)

☐ Excessive Daytime Sleepiness (*Epworth Score* ____ ) ☐ Loud Snoring ☐ Witnessed Apnea

☐ Awaken Gasping/Choking ☐ Morning Headaches / Dry Mouth ☐ Obesity (BMI > 30)

☐ Impaired Cognition (Poor memory or concentration) ☐ Non-Restorative Sleep ☐ Hypertension

☐ Diagnosis: Obstructive Sleep Apnea (327.23) ☐ Diagnosis Other than OSA (indicate code) _____

**CONTRAINDICATIONS FOR HOME SLEEP STUDY:** (*Check all that apply*)

☐ COPD ☐ Congestive Heart Failure (CHF) ☐ Neuromuscular Impairment ☐ Stroke History

☐ Significant Cardiac Disease ☐ Restless Leg Syndrome ☐ Suspected other Sleep Disorders (Other than OSA)

***In the event that an In-Lab Sleep Study is indicated by the Payer, to which Sleep Lab would you like us to refer your patient:***

☐ Athens Regional ☐ St. Mary's ☐ Athens Sleep & Wellness ☐ Athens Pulmonary (*Located in Lavonia)*

**TESTING / TREATMENT OPTIONS** (*Please choose one of the following options*)

☐ **Athens Pulmonary to manage diagnostic and treatment plan for this patient.** (A Sleep Specialist will determine whether HST or In-Lab testing is appropriate)

☐ I request a **diagnostic HST** followed by **Titration Study** if indicated (Auto PAP or In-Lab). Patient will be followed by a Sleep Specialist at Athens Pulmonary for long-term treatment of OSA.

☐ I request a **diagnostic HST Only** with Interpretation by Board Certified Sleep physician. Follow-Up and Treatment (if indicated) will be managed by Ordering Physician.

**Ordering Physician Signature**: _____ **NPI#**: _____

**(Please Fax THIS FORM with COPY OF INSURANCE CARD and H&P or MOST RECENT OFFICE NOTE to 706-549-5825)**