Neuro Diagnostic Sleep Centers

Phone Number: (602) 424-4450
Scheduling Fax: (602) 424-4451
Alt. Scheduling Fax: (602) 354-8531

Date: _____

Referring Provider & Clinic: _____

Patient Demographics	Insurance Card (Front & Back)	All Relevant Notes Dating Back 90 Days
☐ Included ☐ To Follow	☐ Included ☐ To Follow	☐ Included ☐ To Follow

Has your patient had a previous sleep study? ☐ Yes ☐ No **If yes, previous results are:** ☐ Included ☐ Not Available

Patient Name: _____ **Phone:** _____

DOB: _____ SSN: _____ Alt Phone: _____

Primary Language: ☐ **English** ☐ **Spanish** ☐ **Other Language:** _____

Insurance: _____ Policy No: _____

Adjuster: _____ Claim/File No: _____ Auth No: _____

PCP Name: _____ Phone: _____

Diagnosis: _____ ICD-10: _____

PLEASE NOTE: Insurance companies now require that the patient have a face to face consultation before being prescribed PAP therapy

SYMPTOMS: (Please check all that apply)

☐ Witnessed Apnea
☐ Obesity
☐ Hypertension
☐ Excessive Daytime Sleepiness / Fatigue
☐ Persistent / Frequent Snoring
☐ Diabetes
☐ COPD
☐ Cardiovascular Disease
☐ Periodic Limb Movement (RLS)
☐ Choking / Gasping Associated with Awakening
☐ Patient on O_2 Therapy
☐ Insomnia
☐ Other: _____

DIAGNOSTIC SLEEP STUDIES: (Please select one from the list below)

In Lab Sleep Study (PSG)	In Lab Split Night Study (PSG & Titration)	Home Sleep Study (HST)	In Lab Titration
☐ With Consultation	☐ With Consultation	☐ With Consultation	☐ With Consultation
☐ Without Consultation*	☐ Without Consultation*	☐ Without Consultation*	☐ Without Consultation*

* If diagnostic sleep study is performed without **consultation**, the referring physician will be responsible for managing the patient through the sleep process including all therapy and follow-up.

☐ Additional Medical Request: _____

Referring Provider: _____ Fax: _____

Referral Coordinator: _____ Phone: _____

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

Referring Provider Signature: _____

APPOINTMENT INFORMATION:

☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐Saturday ☐Sunday

Date: _____ At _____ A.M. / P.M.

Location: _____

Please Note: To avoid a no-show fee, advanced notice of cancellation is required 72 hours prior to test and 24 hours prior to consult.

For locations and additional information, please visit: **www.ndxlabs.com**

Referring Physician will have results immediately upon completion. Please call if you need clarification or a more specific exam.