



The Sleep Center

Houston Northwest Medical Center

TEST REQUEST INFORMATION FORM

Referral Instructions: Please fax a copy of the patient's history and physical along with this completed form to (281) 397-2720. **We will contact the patient to schedule testing.** Thank you for your referral.

> fax completed information to (281) 397-2720

Referring Physician:

Dr. _____

Tel: _____

Fax: _____

Diagnosis/Sleep Disorder:

- Snoring
- Obstructive Sleep Apnea
- Insomnia
- Excessive Daytime Sleepiness
- Nocturnal Seizure
- Restless Leg Syndrome
- Chronic Fatigue
- Respiratory Distress While Asleep
- Other

CHECK STUDIES DESIRED:

- NOCTURNAL POLYSOMNOGRAPHY (NPSG) - Diagnostic sleep study. Commonly recommended for first time evaluation. **CPT 95810** (if test is positive for sleep apnea, a second night with CPAP titration will be scheduled.)
- CPAP Trial - Therapeutic titration of CPAP. Recommended for patients with documented sleep breathing disorders after NPSG. **CPT 95811**
- NOCTURNAL POLYSOMNOGRAPHY with OPTIONAL CPAP TRIAL - Therapeutic titration of CPAP will be initiated whenever indicated during study. **CPT 95811**
- SPLIT NIGHT STUDY - Diagnostic sleep study and obligated titration of CPAP in a single night study. Commonly recommended for re-evaluation, for optimal pressure, or post surgical evaluation. Titration will be initiated in the second part of the study. **CPT 95811**
- MULTIPLE SLEEP LATENCY TEST (MSLT) - A daytime study to quantify the degree of sleepiness in a patient or to determine specific characteristics consistent with Narcolepsy. **CPT 95805**
- MAINTENANCE OF WAKEFULNESS TEST (MWT) - MWT Recommended for evaluation of extent of daytime somnolence. **CPT 95805**

PATIENT INFORMATION:

Name: _____ Primary Tel: _____ Secondary Tel: _____

Insurance: _____

Date of Birth: _____ Sex: M F SS#: _____

Previous Sleep Studies? Yes No Where? _____

When? _____

Please send a copy of this report.

Physician Signature: _____ Date: _____