# REQUISITION FORM

(Please Specify Desired Location)

☐ South Loop Sleep Lab
2616 South Loop West, Suite 170-B
Houston, TX 77054

☐ Steeplechase Sleep Lab
10694 Jones Rd., Suite 150-B
Houston, TX 77065

☐ Fort Bend Sleep Lab
14031 Southwest Freeway, Suite 605
Sugarland, TX 77478

☐ Katy Sleep Lab
1820 S. Mason Rd. #350
Katy, TX 77450

NATIONAL ASSOCIATES for Sleep
Tel: 1-866-SLP-CNTR (757-2687)
Fax: 1-888-757-2680

## Patient Information (Please Print)

**Name** _____ **Home phone** _____ **DOB** _____

**Street Address** _____ **Work/cell phone** _____ **M/F** _____

**City, State, Zip** _____ **SSN:** _____

**Insurance** _____ **ID #** _____ **Subscriber** _____

## Services Requested

**This Patient is being referred for: (Please check all that apply.)**

**Sleep Study Only**

☐ Diagnostic Sleep Study (95810) — Full night polysomnogram (PSG)

☐ CPAP or BIPAP Titration (95811) — Full night titration for patients with documented sleep apnea

☐ **Consultation and Management** — Visit with NAS specialist to evaluate and treat patient

☐ **Sleep Study & Treatment** — Coordinated Care Referral (CCR), includes sleep study, post study consult, initiate continuous positive airway pressure (CPAP) therapy, if indicated

☐ **Multiple Sleep Latency Test** — Daytime nap test following a full night diagnostic PSG study to diagnose narcolepsy or excessive daytime sleepiness

☐ **CPAP Therapy** — Visit with a CPAP therapist for evaluation and training, mask fitting, compliance monitoring or equipment assessment

## Medical History (Please forward most recent history and physical)

**Suspected Disorder(s)**

☐ Narcolepsy
☐ Nocturnal Seizures/Parasomnias
☐ Insomnia
☐ OSA
☐ Periodic Limb Movements of Sleep, PLMS

**Primary Symptoms**

☐ Loud Snoring
☐ Difficulty falling asleep
☐ Obese/Large Neck
☐ Daytime Sleepiness
☐ Fragmented Sleep
☐ Witnessed Apneas
☐ Frequent leg movements during sleep

**Special Needs**

☐ Nocturnal $O_2$, Level _____
☐ Interpreter, Language _____
☐ Wheelchair _____
☐ Other _____

**Medications** _____

**Comments** _____

**Referring Physician:**

**Name** _____
**Address** _____
**City, State, Zip** _____
**Phone** _____ **Fax** _____
**Email** _____

**Primary Care Physician – Same as Referring Physician?** ☐ **Yes** ☐ **No**

**Name** _____
**Address** _____
**City, State, Zip** _____
**Phone** _____ **Fax** _____
**Email** _____

**Physician's Signature** _____ **Date** _____