MEADOWS

SLEEP CENTER

A division of Meadows Healthcare Alliance, Inc.

505 Maple Drive
Vidalia, Ga. 30474
912-538-5591 Phone
912-538-5592 Fax
888-207-0008 Toll Free
www.meadowssleepcenter.com

When sending sleep study referrals, please include the following:

- Thoroughly completed "SLEEP STUDY ORDER REFERRAL FORM"
- Demographic information for patient to include the insurance information and updated contact information
- Copy of insurance card (s) and photo ID
- ALL clinical notes to support request for sleep study for authorization purposes.

Enclosed is a copy of our referral form for your convenience. If you choose to use a different form, please make sure it includes the following:

- Patient's name and DOB
- Type of study to be done
- Diagnosis code
- Physician's signature

All of this information is needed in order to successfully process the referral in a timely manner and to obtain an authorization from insurance. Your help in providing this information is greatly appreciated.

If you have any questions or concerns please do not hesitate to contact our office at (912) 538-5591 or Toll Free at (888) 207-0008.

We look forward to working with you!

Meadows Sleep Center

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SLEEP STUDY ORDER REFERRAL FORM

Patient Name: _____ Date _____

Address: _____ Phone: (H) (_____)_____

City, State, Zip _____ Phone: (W) (_____)_____

DOB: _____ HT:_____ WT:_____ Sex ☐M ☐F SSN: _____-_____-_____

PRIMARY INSURANCE *(Please send copy of card)*

Company Name: _____ Policy No:_____

Please check the appropriate order:

☐Initial Sleep Study ☐Initial Sleep Study, *(if significant OSA, then schedule 2nd night CPAP Titration)* ☐CPAP Titration *(2nd Night)* ☐CPAP Retitration

☐Post Surgical Sleep Study *(with CPAP Titration if necessary)* ☐Multiple Sleep Latency Test*(MSLT)* ☐Maintenance of Wakefulness Test*(MWT)*

☐PAP-NAP ☐Homestudy PSG ☐Other: _____

Is patient on CPAP? ☐Yes ☐No	**Preliminary Diagnosis:**	**Type of Procedure:**
If yes, _____cmH2O or _____oxygen LPM?	☐ G47.33 Obstructive Sleep Apnea	☐ 95810-PSG
☐ Pre Sleep Study Consult	☐ G47.10 Hypersomnia	☐ 95811-CPAP
☐ List MD to schedule	☐ Other: _____	☐ 95811-52-PAP-NAP

Symptoms of sleep disorder: (Please check all that apply)

☐Witnessed Apnea ☐Snoring ☐Irregular or gasping breathing ☐Hypertension ☐Excessive daytime sleepiness ☐Morning Headaches

☐Loss of muscle control (Cataplexy) ☐Sleep Attacks ☐Sleep Paralysis ☐Restless Legs ☐Insomnia ☐Sleepwalking ☐Obesity

☐Significant weight gain ☐Significant weight loss ☐Fall asleep while driving ☐Loss of sex drive ☐Nocturnal Seizures ☐Heart disease

☐Coronary artery disease ☐Congestive heart failure ☐Pacemaker ☐Pulmonary heart disease ☐Pulmonary HTN ☐Respiratory disease

☐COPD ☐Emphysema ☐Tuberculosis ☐Sarcoidosis ☐Lung Cancer ☐Idiopathic Pulmonary Fibrosis ☐Pulmonary edema ☐ADD

☐ADHD ☐Bipolar ☐Neuromuscular disease in facial area ☐Mood disorders ☐Other: _____

THE PURPOSE OF THIS PROCEDURE IS TO DETERMINE IF THIS PATIENT HAS OBSTRUCTIVE SLEEP APNEA

Referring: Physician Name _____ Phone_____

Address _____ Fax _____

_____ UPIN#_____

Physician Signature _____ Office contact:_____

BAXLEY * SWAINSBORO * VIDALIA

Please fax this order form, copy of insurance card, and pre-certification form, and any other pertinent medical history to 912-538-5592. If you or your patient have any questions please do not hesitate to contact our office @ 888-207-0008 or 912-538-5591.