MEDICAL REFERRAL FORM

SCOFA SLEEPCARE
Better Sleep, Better Health

Physician Information

Provider _____ Practice _____ Telephone _____

Fax _____ Email _____ Contact/Referral Coordinator _____

Patient Information

Patient Name _____ Date of Birth _____ Phone _____

Alternate Phone _____ Email _____ City _____

Fax Patient's Demographics with this Referral or you can submit the Referral online at ScofaSleepcare.com
Please provide a copy of the insurance card (Front and Back) if available

Section A - Reason for the Consultation

☐ Sleep Apnea Evaluation ☐ Insomnia Evaluation ☐ Other Sleep Disorder Evaluation _____

Section B - Medical History

Please check all that apply

☐ **Hypertension**	☐ **Impaired Cognition**	☐ **History of Stroke**	☐ **Ischemic Heart Disease**
☐ **Mood Disorders**	☐ **Excessive Daytime Sleepiness**	☐ **Insomnia**	☐ Atrial Fibrillation
☐ Reflux	☐ Witnessed Apnea	☐ Congestive Heart Failure	☐ Diabetes
☐ Memory Loss	☐ Depression	☐ Sleep Disturbance	☐ Seizures
☐ Morning Headache	☐ Nocturia	☐ COPD	☐ Large neck size (greater than 17″ for men, greater than 16″ for women)

Insomnia Related

☐ Difficulty Falling Asleep ☐ Difficulty Staying Asleep ☐ Waking up too early Other _____

Is Patient on Oxygen? ☐ Yes ☐ No **How much Oxygen liter per minute?** _____

Section C - Diagnostic Codes

Please check at least one that applies.

- ☐ G47.33 Obstructive Sleep Apnea
- ☐ G47.10 Other Hypersomnia-Excessive Daytime Somnolence
- ☐ G47.00 Insomnia, unspecified
- ☐ G47.01 Insomnia due to a medical condition
- ☐ F51.01 Primary insomnia
- ☐ F51.05 Insomnia due to other mental disorders

Other _____

Section D - CPT Home Sleep Testing

- ☐ Commercial 95800
- ☐ Medicare G0399
- ☐ Self-Pay

Comment _____

_____

Referring Physician Signature _____ Date _____