



ELITE SLEEP

Physician Referral Form

Phone 425.377.9988 | Fax 425.880.5815

Date: _____

Patient's Name: _____ DOB: _____

Male/Female: _____ Patient's Phone: _____ Email _____

Insurance Company: _____ Insurance Phone: _____

Services Ordered:

- NPSG (Overnight Sleep Study)
- Split Study (50/50 Overnight Sleep Study with CPAP Titration) if AHI is greater than _____
- CPAP Titration only
- BiPAP Titration
- ASV Titration
- OAT Titration
- NPSG with MSLT to follow (Overnight Sleep Study with Daytime Nap following)
- Add oxygen if SAO2 is below _____%**

History & Physical:

- Snoring
- Apnea witnessed by family member or bed partner
- Excessive daytime somnolence; **ESS Score:** _____
- Leg twitching
- Seizures
- Frequent awakenings
- Nasal Congestion
- Obesity
- Deviated Septum
- COPD/Asthma
- Hypertension
- Cardiac Abnormalities
- Other Neurological disorders
- Other Pulmonary disorders
- Other: _____

Physician's signature: _____

Physician's Name: _____

Physician's mailing address: _____

Physician's Phone: _____ Fax: _____

Thank you for your referral, we will contact patients within 2 business days!