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Sleep Medicine Referral Form & ICD-10 Codes for Services

Section 1:

Patient Name:	Referring Physician:
Address, City, State, Zip:	Address, City, State, Zip:
Date of Birth:	Phone:
Home Phone:	Fax:
Cell Phone:	Email:
Work Phone:	National Provider Identifier:

Section 2: Sleep Disorders/Diagnostic Services (required)

- ☐ Telemedicine Assessment for Sleep Disorder
- ☐ Baseline Home Sleep Test (HST)

Section 3: Symtoms & Reason For Referral (Please attach recent consult notes)

- ☐ G47.10 Hypersomnia, unspecified
- ☐ G47.13 Recurrent hypersomnia
- ☐ G47.14 Hypersomnia due to medical condition
- ☐ G47.30 Sleep Apnea, unspecified
- ☐ G47.33 Obstructive Sleep Apnea (adult/pediatric)
- ☐ G47.19 Other hypersomnia

PRACTITIONER SIGNATURE

SPECIAL REQUESTS

DATE

PATIENT INSURER NAME AND INSURANCE ID#