

Specialty Service Referral Sleep Disorders Center

SBL Sleep Disorders Center
Prairie Pavilion 1 • 1005 Health Center Dr., Suite 106 • Mattoon, IL 61938
217-238-4098 • Fax 217-238-4909



REFERRING PROVIDER

Name _____ Phone _____ Fax _____
Reason for Referral _____ Date _____

PATIENT INFORMATION

Name _____ Date of Birth _____ Social Security Last 4# _____
Address _____ City _____ State/Zip _____
Phone _____ County _____
Insurance Carrier Primary _____ Secondary _____
ID# _____ Precertification/Auth# _____

INFORMATION NEEDED

ICD10 Codes (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> G47.30 — Sleep apnea, unspecified | <input type="checkbox"/> G47.52 — REM sleep behavior disorder |
| <input type="checkbox"/> G47.31 — Primary central sleep apnea | <input type="checkbox"/> G47.411 — Narcolepsy with cataplexy |
| <input type="checkbox"/> G47.10 — Hypersomnia, unspecified | <input type="checkbox"/> G47.42 — Narcolepsy without cataplexy |
| <input type="checkbox"/> G47.61 — Periodic limb movement disorder | <input type="checkbox"/> G47.5 — Parasomnia, unspecified |
| <input type="checkbox"/> Other _____ | |

1. Does patient currently use CPAP/BIPAP/ASV? Yes No
2. Has the patient had a face-to-face encounter within the last 4 months to document signs and symptoms for sleep apnea? Yes No
When was the face-to-face visit? _____
3. Has the patient had a previous sleep study Yes No
4. Has the patient had a previous diagnosis of sleep apnea? Yes No
If yes and study was done outside of SBL, please fax sleep report to 217-238-4909
5. Does a caregiver need to stay due to special needs or is the patient under 17 years old? Yes No
6. Does the patient use a wheelchair, walker or cane? Yes No
7. Does the patient need a Hoyer lift? Yes No
8. Does the patient snore? Yes No
9. Does the patient feel tired, fatigued or sleepy during daytime? Yes No
10. Has anyone observed the patient stop breathing during sleep? Yes No
11. Does the patient have high blood pressure? Yes No
12. Patient's Weight _____ Height _____ BMI _____

Continued on back

Procedures

95811— **Split Night Study**

First portion of the study is for screening purposes. If patient meets criteria, CPAP is started.

95811— **Titration Study** – CPAP BIPAP ASV

Sleep study using a PAP device for treatment of sleep apnea, snoring, hypoxia or other sleep-related disorders.

(This test requires a diagnosis of apnea from a previous sleep study; please fax all previous studies to 217-238-4909)

95805 & 95810— **Multiple Sleep Latency Test (MSLT) Maintenance of Wakefulness test (MWT)**

OR Nap studies to evaluate sleepiness and/or narcolepsy performed the morning following a full night PSG

95805 & 95811— Or order 95805 with 95811 for persons already diagnosed with sleep apnea and who currently use a CPAP machine

95806— **Home Sleep Study**

Portable monitoring equipment used to assess snoring and sleep apnea in the patient's home.

Please select location for patient to pick up home sleep test device: **Mattoon** **Effingham**

REFERRING RESPONSE

Patient Scheduled

Provider _____ Date _____ Time _____

Comment _____

Patient NOT Scheduled

Additional Information Required _____

Other Reason _____