

Office Phone

Pediatric Sleep Testing Referral

Please attach copy of insurance card, patient demographics, and provider notes and fax to: (303) 957-5414

Fax: (303) 957-5414 OR 719-387-8690 Phone: (303) 396-5923 OR 719-387-8685

■ We will call your patient for scheduling within 24 hours.	■ Scheduling within 7 days, pending insurance authorization.	■ "Kid- friendly" environment. (non-hospital setting)
Patient Name:		
Guardian Name:		
Patient Date of Birth://_	Phone: ()	
Overnight Sleep Study Reques	sted:	
☐ Baseline Diagnostics polysomn if <6 years of age)		e 95810 if >6 years or 95782
☐ Split Night - Baseline polysomnogra if >6 years or 95783 if <6 years of age)		tion if appropriate. (CPT code 95811
☐ CPAP Titration (CPT code 95811 if	>6 year or 95873 if <6 years of age)	
	or patients with suspected Narcolepsy. (C is night (CPT code 95810 if >6 years or 9	PT 95805) Baseline with capnography will 5782 if <6 years of age)
\square Standard Seizure Montage (CPT	code 95810 if >6 years or 95782 if <6 years	ars of age)
\square Consultation (Our doctors will consu	ult, order tests and equipment as needed)	
Reason for Sleep Study:		
☐ Apnea(327.23, 327.21)	☐ ENT surgical candidate	☐ Other
☐ Seizure(345.80)	☐ Night Terrors(307.46)	
Other Medical Conditions:		
☐ ADD or ADHD	☐ Down Syndrome	☐ Tracheostomy
(Possibly due to sleep apnea)	☐ Autism	☐ Epilepsy
☐ Snoring	☐ Cerebral Palsy	☐ Other
Accommodations' for Parents	·	
☐ Adult will need private room	☐ Adult will no	
☐ Adult will stay in room with child	(Children 15 years of age and younger must have an adult stay with them for the entire night.)	
Physician Signature		Date
Physician Name (Print)		

Insurance Information: We will verify coverage and obtain prior authorization.

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