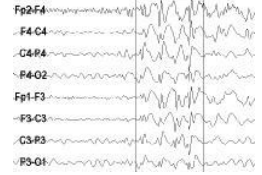




**San Jose Pacific Neurology Center P.C.**  
**AASM Accredited Sleep Center # 355200**  
**Raj Gupta MD**  
**Board Certified Sleep specialist**



**SLEEP STUDY REFERRAL FORM**

**PATIENT DEMOGRAPHICS**

**Patient:** \_\_\_\_\_ **Soc. Sec. #** \_\_\_\_\_ **D.O.B** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Contact: Home Phone** \_\_\_\_\_ **Work/Cell Phone** \_\_\_\_\_

**STUDY TO BE DONE**

**Consultation** followed by sleep study

**Diagnostic Study:**

- All-Night Diagnostic Polysomnography (CPT-95810)
- Home Sleep Apnea testing (HSAT) (CPT 95806)

**Treatment Study:**

- All-Night CPAP/BiLevel Titration Study (CPT-95811)

**Combination Diagnostic/Treatment Studies**

- Split Night Study (CPT-95811) Diagnostic with PAP pressure determination

The above referenced patient has an absolute medical necessity for the item(s) listed above, based on the following diagnosis:

**Suspected Diagnosis** (Check appropriate boxes)

- Obstructive Sleep Apnea (OSA)     Narcolepsy     Other

**Relevant Medical History** (Check appropriate boxes)

- Hypertension     CHF     Stroke     CAD     Diabetes mellitus     Arrhythmia (VT/Afib)
- Other \_\_\_\_\_

**PHYSICIAN NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_

**TEL:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**NPI #** \_\_\_\_\_

**UPIN #** \_\_\_\_\_

**CONTACT:** \_\_\_\_\_

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Note: Please fax copy of insurance card (front & back) with Referral Form.**

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