

SLEEP DIAGNOSTIC CENTER

Accredited by American Academy of Sleep Medicine

KRIS BHAT, M.D.

Medical Director

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PHONE (281)548-7313
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REFERRAL/ORDER FORM FOR SLEEP STUDY

Name: _____ Date: ____/____/____

Address: _____ City: _____ ST: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

DOB: ____/____/____ SSN: ____-____-____ Ins: _____ HMO or PPO

ID#: _____ Grp#: _____ Ins Ph #: _____

Referring Physician: _____ Phone #: _____

Nocturnal Polysomnography
C-PAP Titration
Parasomnia
Split-night Protocol 2 hour diagnostic/CPAP/Bi-PAP/Auto PAP titration
Nocturnal Polysomnography with MSLT next day
Patient will need supplement O2 _____ liters
Sleep Consult with Dr. Bhat

Instructions: _____

This patient is being referred out of the medical necessity to the Sleep Diagnostic Center for sleep study to diagnose sleep disorders. The patient has the following signs and symptoms as marked:

Excessive day-time sleepiness	Loud snoring
Spouse indicates patient stops breathing at night	Morning headaches
Excessive movements while "asleep"	Memory problems
Sexual problems/impotence	Personality, mood changes
Arousals (Insomnia)	Possible narcolepsy

Other symptoms: _____

Ordering Physicians Signature: _____ Date: ____/____/____

****Please fax a copy of the patients insurance card (front & back) and patients history and physical to our office with this form to 409-835-5451 (Beaumont patients) and to 281-446-6818 (Humble patients).**

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