OSAinHOME℠ Patient Referral Form

Thank you for choosing OSAinHOME℠ for your patient's sleep-related issue. Our OSAinHOME℠ program provides complete diagnosis and treatment for obstructive sleep apnea in the convenience and comfort of your patient's home. Once all documentation is received from you, our staff will contact your patient and explain the process and answer all questions. Reports of progress will be sent to your office to keep you informed of your patient's care every step of the way. If you have questions, please call us at (615) 427-4228.

Patient Name: _____ Date of Birth: _____

Address: _____

City, State & Zip: _____

Primary Phone: _____ Cell Phone: _____

Email Address (Required): _____ SSN: _____

Referring Physician: _____ Physician Phone: _____

Primary Insurance: _____ ID No: _____

Secondary Insurance: _____ ID No: _____

SLEEP STUDY ORDER (required if patient should immediately have a sleep study without consult)

☐ Home Sleep Study (95800) **ORDER**

Justification (*For Insurance Purposes)*:

☐ Cardiovascular Disease (Any Type)
☐ Diabetes/Insulin Resistance
☐ Hypertension
☐ Cognitive Impairment
☐ Mood Disorders
☐ Erectile Dysfunction
☐ Nocturia
☐ BMI > 30
☐ Snoring
☐ Fatigue/Sleepiness
☐ Side Sleeper
☐ Witnessed Apnea or
☐ Gasping during sleep
☐ Use of Alcohol,
☐ Sedatives, or Pain Meds
☐ Other _____

DIAGNOSIS ICD and Description

☐ G47.33 Possible Obstructive Sleep Apnea

Additional Instructions: _____

_____

_____

Ordering Provider Name: _____ **Signature:** _____
(please print)

Previous Sleep Study Order (Required if patient has had a previous sleep study)

☐ My patient has had a previous sleep study. I have included a copy of the results with this form.

OSAinHome℠ Is a Division of Sleep Centers of Middle Tennessee.

Please fax completed form, latest progress note, and insurance card (if available) to 615-893-4821

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