Stationery Proof - 5.5"w x 8.5"h - 50 sheets per pad Designer TJ

☒ New Job ☐ Exact Reprint

☐ Reprint with Changes: _____

Item: Referral Note Pad Quantity: TBD Paper: Uncoated Printing Process: Full Color

theREALsleep

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Grove City, OH 43123

305 S. Hamilton Road
Gahanna, OH 43230

7713 Sawmill Road
Dublin, OH 43016

tel 614-222-6816 • *fax* 614-871-0500

info@the REALsleep.com • theREALsleep.com

PATIENT NAME: _____

DOB: _____

Phone: _____

Email: _____

Address: _____

Insurance Provider: _____

Insurance Policy Number: _____

Insurance Phone Number: _____

Insurance Group ID: _____

REFERRING PHYSICIAN NAME: _____

License: _____

NPI: _____

Phone: _____

Email: _____

Office Name: _____

Address: _____

Office Tax ID: _____

Office NPI: _____

PRESCRIPTION FOR AT-HOME SLEEP TEST

SLEEP HISTORY & PRESENTING SYMPTOMS:

- ☐ Snoring
- ☐ Witnessed Apnea
- ☐ Morning Headaches
- ☐ Nocturia
- ☐ Daytime Sleepiness
- ☐ Fatigue
- ☐ Congestive Heart Failure
- ☐ Nocturnal Awakenings
- ☐ Impaired Cognition
- ☐ Diabetes
- ☐ Insomnia
- ☐ Non-Restorative Sleep
- ☐ Bruxism
- ☐ Restless Leg / Periodic Limb Movements
- ☐ Central Sleep Apnea
- ☐ Stroke
- ☐ Hypertension
- ☐ Obesity (BMI:____)
- ☐ CPAP Intolerant
- ☐ Other Symptoms _____

SUSPECTED DIAGNOSIS:

☐R/O Sleep Apnea	G47.33
☐Treat OSA	G47.33
☐Treat CSA	G47.31
☐Treats Complex SA	G47.31
☐Re-Titration for OSA	G47.33
☐R/O	G47.61
☐R/O Narcolepsy	G47.419
☐Restless Leg Syndrome	G25.81
☐Snoring	R06.83
☐Other:_____	G47.33

❑ Oral Appliance

☐ Testing Consultation & Treatment Management

(Once the study is completed, North Georgia Sleep Solutions will review the Results with the patient at a consultation appointment after the study. Initiation of treatment and on-going management by Board-Certified Sleep Physician & North Georgia Sleep Solutions.)

_____

(PROVIDER SIGNATURE) *(DATE)*