Hartford HealthCare
Backus Hospital

Sleep Disorders Center | Sleep Study Requisition

Backus Sleep Care Center
Tel: 860.425.4699 Fax: 860.425.4698

☐ **Backus Campus**

Patient Information

Patient Name: _____ Birth Date: _____ ☐ Male ☐ Female

Address: _____

Home Phone: _____ Day Phone: _____ Cell Phone: _____

Primary Insurance: _____ Co-Insurance: _____

Subscriber #: _____ Subscriber #: _____

PLEASE SEND MOST RECENT OFFICE NOTES RELATED TO THIS REFERRAL

Test Information

Study Requested:

- ☐ Consultation with Comprehensive Management (Consultation with Sleep Specialist which includes Sleep Testing (95810/95811), ordering of equipment and follow up as needed.)

  ***Home Sleep Apnea Test (95806) will be performed if the patient does not meet insurance criteria for an attended study*

- ☐ Sleep Testing Only (Testing results will be sent to the referring provider for follow up)
  - ☐ Diagnostic Polysomnogram (95810)
  - ☐ CPAP/BiPAP Titration Study (95811)
  - ☐ Home Sleep Apnea Test (95806)
  - ☐ Specific Request: _____

Indication for Sleep Study:

- ☐ Snoring
- ☐ Day Time Sleepiness
- ☐ Observed Apnea or Gasping
- ☐ Nocturnal Sleep Disruptions
- ☐ Morning Headache

Suspected Disorders:

- ☐ Sleep Apnea, suspected (G47.30)
- ☐ Obstructive Sleep Apnea, previously diagnosed (G47.33)
- ☐ Insomnia (G47.00)
- ☐ Periodic Limb Movement Disorder (G47.61)
- ☐ Other

Referring Physician Signature: _____ Date: _____ Time: _____

Physician Printed Name _____ Phone: _____ Fax: _____