Somnus
Sleep Center


## Somnus Sleep Center
3575 Old Washington Road, Suite C
Waldorf, MD 20602
Phone (301) 638-5500 • Fax (301) 638-5511


# SLEEP REFERRAL ORDER

PATIENT INFORMATION

Name (First, Last) _____ Date of Birth (mm/dd/yy) _____

Daytime Phone _____

REFERRING PHYSICIAN

Name (First, Last) _____

Phone _____ Fax _____

Signature _____

- ☐ Sleep Consultation
- ☐ Split Night PSG
- ☐ Multiple Sleep Latency Test (MSLT)
- ☐ Polysomnogram
- ☐ Home Sleep Test
- ☐ Maintenance Wakefulness Test (MWI)
- ☐ CPAP Titration
- ☐ PAP-NAP
- ☐ Other _____

SYMPTOMS

- ☐ Hypertension
- ☐ Loud Snoring
- ☐ Insomnia
- ☐ Restless Sleep
- ☐ Obesity
- ☐ Witnessed Apnea
- ☐ Morning Headache
- ☐ Excessive Daytime Fatigue
- ☐ Other _____

SUSPECTED DIAGNOSIS

- ☐ Obstructive Sleep Apnea
- ☐ Narcolepsy
- ☐ Restless Sleep
- ☐ Parasomnia
- ☐ Insomnia
- ☐ Other _____

DME - CONSULTATION AND DISPENSE

- ☐ CPAP
- ☐ BIPAP
- ☐ AutoPAP
- ☐ Humidifier
- ☐ E0601 Device
- ☐ A7034 Nasal Mask
- ☐ A7035 Headgear
- ☐ E0562 Heated Humidifier
- ☐ A7037 Tubing
- ☐ A7038 Filter
- ☐ Automatic Supply per Guidelines

Period of: ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ 4 Months ☐ 5 Months ☐ 6 Months

I certify the above information is true and correct to the best of my knowledge. I further certify this test and DME equipment is medically necessary.

Physician Signature _____ Date _____


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Please FAX this completed referral form
and patient visit notes to (301) 638-5511.

*Thank you.*