SLEEPCYCLE
A GOOD NIGHTS REST BEGINS HERE

Date: _____

Prescription for At-Home Sleep Test:

Name : _____

DOB : _____

Phone : _____

E-mail : _____

Insurance Info : _____

Please also provide patient's insurance information, pertinent medical history and any recent sleep studies.

Sleep History & Presenting Symptoms (check all that apply):

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

Service:

_____ **Home Sleep Test**

(Once the study is completed, our office will send the results to the ordering physician for follow-up with the patient. All studies are interpreted by a Board-Certified Sleep Physician in Austin.)

_____ **Testing Consultation & Treatment Management**

(Review of results with the patient at a consultation appointment after the study, initiation of treatment and on-going management by Board-Certified Sleep Physician & Sleep Cycle Center.)

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 PLMS	*G47.61*
☐ R/O Narcolepsy	*G47.419*
☐ Restless Leg Syndrome	*G25.81*
☐ Snoring	*R06.83*
☐ Other: _____	*G47.33*

Prescription to be filled by & sent to:

Sleep Cycle Center:

HIPAA-Compliant Email: drdenman@sleepcyclecenters.com

Fax: 1-512-645-0646

Referring Physician Name: _____

NPI: _____

Office Phone: _____

Office Fax: _____

Physician Signature: _____

Email &/or fax all recent clinical notes and **Completed** form to:

drdenman@sleepcyclecenters.com
Office: (512) 645-0818
Fax: 1-512-645-0646

SLEEPCYCLE
A GOOD NIGHTS REST BEGINS HERE

Date: _____

Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea (OSA)

Patient Information

Name: _____

DOB: _____

Home address: _____

_____

Email: _____

Phone #: (_____) _____

Insurance Policy # : _____

Insurance Phone # : (_____) _____

**Please fax a copy of patient's medical insurance card with this RX.*

Referring Physician Information

Name: _____

License #: _____

NPI #: _____

Office Name: _____

Office Tax ID #: _____

Office NPI #: _____

Address: _____

_____

Phone #: (_____) _____

Fax #: (_____) _____

Email: _____

Signature: _____
*As a physician, I deem this therapy to be medically necessary.

Prescription to be filled by & sent to:

Sleep Cycle Center:

HIPAA-Compliant Email: drdenman@sleepcyclecenters.com

Fax: 1-512-645-0646

The patient referred with this form has been evaluated by the above physician and has been diagnosed to have acceptable medical criteria for:

☐ G47.33 **Obstructive Sleep Apnea** ☐ R06.83 **Snoring**

This Patient is:

☐ Intolerant of C-PAP Therapy

☐ Is ***not*** a candidate for C-PAP Therapy

☐ _____
_____
_____
_____

The patient is being sent for E0486 Mandibular Advancement Splint therapy with:

☑ The appliance chosen by the Patient and *Sleep Cycle Center*, as most suitable.