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: info@sleepcyclecenter.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:

info@sleepcyclecenter.com
Office: (512) 645-0818
Fax: 1-512-645-0646