United STAT Sleep Centers

REFERRAL FORM

Phone: (562) 622-1002 • Fax: (562) 622-1058

Please fax this completed form including supporting documents
(DEMOGRAPHICS, INSURANCE CARD FRONT & BACK)
You may fill out this form online at: www.statsleep.com or email: rx@statsleep.com

Section 1: Patient Demographics *(If Complete Demographic is included with this form, skip to **Section 2**.)*

Patient Name: _____ **Date:** _____

Please check one: ○ **Male** ○ **Female**

Address: _____ **City:** _____ **Zip Code:** _____

Home Phone #: _____ **Cell Phone #:** _____

Date of Birth (DOB): _____ **Email:** _____

Section 2: Diagnosis *(If Diagnosis is included on RX, skip to **Section 3**.)*

○ **Apnea Events** ○ **Chronic Fatigue** ○ **Seizures** ○ **Insomnia** ○ **Narcolepsy** ○ **Restless Legs**

○ **Other:** _____

Section 3: Study Selection

Overnight Study: ○ **95810 (PSG Sleep Test)** ○ **95811 (CPAP Titration)** ○ **95811 (Split Study)**

Other Sleep Test:

○ **95807-52 PAP NAP** - Ideal for Non Compliant CPAP users

○ **95805 MSLT** - (Multiple Sleep Latency Test)

○ **95805 MWT** - (Maintenance of Wakefulness Test)

○ **95810 + 95827 Seizure Montage Study** - Check for Nocturnal Seizures & Parasomnias

---

Home Sleep Test:

○ **G0399**

○ **Consultation for sleep disorders**

Physician Name: _____ **Phone #:** _____

Signature: _____ **Date:** _____

11411 Brookshire Ave. Suite 505 Downey, CA 90241

Tel: (562) 622-1002 • **Fax:** (562) 622-1058 • **Email:** info@statsleep.com • **Web:** www.statsleep.com