Wesley Neurology Sleep Center
8000 Centerview Parkway, Ste. 305
Cordova, TN 38018
O: (901) 259.5190 F: (901) 259.2202

Patient Name: ____________________________DOB: ____/____/____SSN:__________________ ☐ M ☐ F

Address: ________________________________ City: _________________ State: ________Zip:________

Home Phone: _________________ Work Phone: _______________Cell Phone _________________

Emergency Notification: ________________________Relationship________________ Phone: _________________

PLEASE INCLUDE COPY OF INSURANCE CARDS FRONT AND BACK WITH DEMOGRAPHICS

Please select one:
(1) **Referral**: ☐ **Y** ☐ **N** Consult with sleep physician, sleep study, diagnosis, and treatment.

(2)**Direct Referral**- ☐ **Y** ☐ **N** Patient **will not** meet with a sleep medicine physician.
The referring physician maintains the care of the patient by initiating the treatment plan and following the patient's progress including DME orders if needed. **In order to uphold the accreditation of our sleep testing facility, we are required by the American Academy of Sleep Medicine to obtain a recent H&P for all patients referred for a direct sleep study. For direct referred patients the H&P must meet insurance guidelines to schedule as a direct referral. Please include a list of all medications.**

PLEASE NOTE: Any referrals not supporting the ordered sleep study the patient will be referred to the clinic to see Dr. Marc E. Hofmann for evaluation prior to sleep testing.

Clinical: HT________WT_________ Neck Circumference _________

☐ Witnessed/Suspected Sleep Apnea ☐ Diabetes ☐ Cardiac Disease ☐ COPD ☐ Hypertension ☐ Obesity
☐ Mood Disorder ☐ History of OSA ☐ Snoring ☐ Excessive Daytime Sleepiness ☐ Morning Headaches
☐ Stroke ☐ Narcolepsy ☐ Pre-Bariatric ☐ Seizures ☐ Rem Behavior Disorder ☐ ALS ☐ MDA

Please Select Study

Diagnostic sleep study (polysomnogram) *urgent CPAP (Split Night) may be applied per established protocols	☐ CPT 95810	DOT Employee______ CDL Driver____ Other______________	☐
Split night sleep study * Patient must meet established criteria	☐ CPT 95811	**MSLT day study** *followed by a diagnostic sleep study	☐ CPT 95805
Titration Sleep Study * Previous diagnostic sleep study required	☐ CPT 95811	**MWT day study** * Maintenance of Wakefulness	☐ CPT 95805
Portable Study (UNATTENDED) * Home Sleep Apnea Testing Type III	☐ CPT 95806	**OTHER**	☐

Referring Physician: ______________________________ Specialty: _______________

Office Phone: ____________________________ Fax: ____________________________

Office Contact: ____

REFERRING PHYSICIAN _________________________________***NPI#***_______________

MUST BE SIGNED BY PHYSICIAN

REVISED 6/2017 EB