203 Telluride St. Unit 750 Brighton, CO 80601
Phone: 720-408-9406
Fax: 303-459-5537 or 1-888-980-1006

Patient Name:_____ Male/Female **DOB:** _____
Address: _____ **City:** _____
State/Zip:_____ **Phone#** _____
Insurance: _____
Preferred DME Company:_____

Type of Referral

___**2-night In-Home Sleep Study** (HST) 95800/95806/G0399

___**2-night In-Home Sleep Study With Consult** (Sleep Doctor will order therapy and maintain compliance after testing is completed)

___**2-night In-Home Sleep Study with Oral Appliance** (HST) 95800/95806/G0399

___**Sleep Consultation** (Sleep Doctor will consult with your patient and order testing or therapy as needed)

Diagnosis

___OSA G47.33 (Select this option to rule in/out OSA)

___Other: _____

Insurance Requirements

- Current chart notes/Sleep Questionnaire (notes must be within 90 days of this order date)
- Demographics (patient's address, insurance information)
- Copy of front and back of the patient's insurance card

Ordering Physician

Physician Printed Name: _____ **NPI#:** _____

Signature: _____ **Date:** _____

Address: _____

Phone: _____ **Fax:** _____