



Oklahoma Heart Institute Sleep Care

Oklahoma Heart Sleep Center Locations (please circle if preference)

Midtown Bailey Claremore Cushing Henryetta

1. Patient Name _____ Date of Birth _____

Best Daytime Phone Number _____

Please send Demographic Sheet

Name of Person Completing Form _____

Referring Provider Name _____ NPI # _____

Phone _____ Fax _____

Authorization # _____ (hard copy if available)

2. Insurance Information: Please fax enlarged copy of front and back of insurance card

Indications	Medical Conditions <small>(Please check all that apply)</small>
1. Sleep Apnea, Obstructive (G47.33) 2. Snoring (Not for Medicare) (R06.83) 3. Excessive Sleepiness/ Hypersomnia..... (G47.10) 4. Primary Insomnia (F51.01) 5. Sleep Related Movement Disorders..... (G47.69) 6. Sleep Apnea Unspecified (G47.30) * Please Send a Copy of Any Previous Sleep Testing and Last Office Note.	<input type="checkbox"/> Hypertension (I10) <input type="checkbox"/> Atrial Fibrillation (I48.91) <input type="checkbox"/> Diabetes Mellitus (E11.9) <input type="checkbox"/> Obesity (E66.9) <input type="checkbox"/> CAD (I25.10) <input type="checkbox"/> Congestive Heart Failure (I50.9) <input type="checkbox"/> Stroke..... (I63.9) <input type="checkbox"/> Chronic Obstructive Pulmonary Disorder. (J44.9) <input type="checkbox"/> Chronic Opioid Use (F11.10) <input type="checkbox"/> Neuromuscular Disorders <input type="checkbox"/> Other _____
Epworth Sleepiness Scale <small>(Please ask patient to complete prior to sending referral)</small>	Referring Provider Orders
What are the chances that you would doze off? 0 - Never, 1 - Slight, 2 - Moderate, 3 - High Sitting and reading..... _____ Watching TV _____ Sitting, inactive in a public place..... _____ As a passenger in a car for an hour without a break _____ Lying down to rest in the afternoon..... _____ Sitting and talking to someone _____ Sitting quietly after lunch without alcohol _____ In a car, stopped for a few minutes in traffic.. _____ Total: _____	<input type="checkbox"/> Comprehensive Sleep Care—Sleep Consultation, Testing, Treatment and Follow Up <input type="checkbox"/> Split Night Sleep Study—Diagnostic Sleep Testing with CPAP Titration if criteria for sleep apnea is met (95811) <input type="checkbox"/> Diagnostic Sleep Study Without CPAP Titration (95810) <input type="checkbox"/> CPAP Titration Study—Patient already has established diagnosis of sleep apnea. Copy of previous sleep study must be available (95811) <input type="checkbox"/> Maintenance of Wakefulness Test (MWT) (95805)

Ordering Provider's Signature _____ Date _____

* Please send a copy of any previous sleep testing and last office note.
Please fax completed form to 918-747-5003.

If you have questions regarding OHI's Sleep Care program, please contact Oklahoma Heart Institute Sleep Care at 918-747-5337 (option 3).