Bluepoint MEDICAL ASSOCIATES

CENTREVILLE 14631 Lee Highway | Ste 413
LANSDOWNE 19420 Golf Vista Plaza | Ste 350
LAKE RIDGE 2080 Old Bridge Road | Ste101
SPRINGFIELD 6128 Brandon Ave | Ste 208

web BluepointMed.com phone 703.385.8222 fax 703.832.8809

Sleep Referral Form

Patient Name (First, Middle, Last)		Date of Birth (MM/DD/YYYY)
Patient Address		Primary Phone
Primary Care Physician		Physician Phone
Insurance	Policy Number	Group Number
Primary Language: ❒ English ❒ Spanish ❒ Other:		

SLEEP ORDER:

All patients will consult with our Board Certified Sleep Physician for an initial sleep evaluation then again if necessary to review test results and discuss treatment options

☐ Consultation with Sleep Specialist

☐ **Polysomnogram, SPLIT night Polysomnogram (if needed), Home Sleep Test (if needed), PAP titration (if needed)**

➥ ☐ Arrange DME for patient (PAP Initiation & Management (94660))
or ☐ Referring Doctor will arrange DME (if needed)

☐ Polysomnogram (95810)
☐ CPAP/BiPAP Titration (95811)
☐ SPLIT Night Polysomnogram (95811)
☐ Maintenance of Wakefulness Test (95805)
☐ Multiple Sleep Latency Test (95805)
☐ Home Sleep Test (95806)
☐ PAP Initiation & Management (94660)
☐ Other:

If the patient is <u>not</u> being referred for an initial consultation please provide the following information:

1. Please fax the last office visit notes suggesting need for sleep study
2. Patient Height:_____ Weight:_____ BMI:_____
3. Epworth Sleepiness scale

MEDICAL HISTORY:

(Check all that apply)

Suspected Disorders
❒ Obstructive Sleep Apnea
❒ Narcolepsy
❒ Restless Leg Syndrome/ Periodic Limb Movements of Sleep
❒ Parasomnia
❒ Insomnia
❒ Other:_____

Medical Problems
❒ Depression
❒ Anxiety
❒ ADD/ADHD
❒ Hypertension
❒ Diabetes
❒ Other:_____
❒ CAD, MI, or CHF
❒ Stroke
❒ Fibromyalgia
❒ Asthma
❒ Arrhythmia

Symptoms
❒ Pre-Operative Screening
❒ Snoring
❒ Headaches
❒ Overweight
❒ Motor Vehicle Accidents
❒ Nocturia
❒ Concentration/Memory
❒ Sleepiness/Fatigue
❒ Other:_____

Facility Name		
Physician Name		NPI:
Physician Address		
Physician Phone		Physician Fax:

DID YOU REMEMBER?

- FAX this referral form to our fax number at (703) 832-8809
- Attach office visit notes for insurance authorization purposes
- If your patient has had a previous sleep study at another facility, please include those results.

PHYSICIAN STATEMENT: I have carefully reviewed this form and find this test to be medically necessary.

REQUIRED*

Physician Signature: _____ **Date**: _____