Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone Number: (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: Sleep Apnea/ Sleep Related Breathing Disorder Obstructive Sleep Apnea Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE CHECK ALL THAT APPLY:**

1. **Sleep Medicine consult** – Reason for consult: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Consult** – Patient will see Dr. Gill (Sleep Specialist) prior to having sleep study, we will manage their CPAP
3. **Management** – Dr. Gill to discuss sleep study results, coordinate with DME company to set up the patient on CPAP/Bi-level, if necessary and manage sleep problems
4. **Sleep Study Only Without Prior Consult with Dr. Gill** – (Patient should meet the criteria for a sleep study)
5. **Split Night Sleep Study** (Will be performed if the patient meets the criteria) Otherwise **Followed by CPAP Titration Study** if positive for sleep apnea.
6. **CPAP/ BILEVEL Titration Study. (**Only **Bi-level** if patient unable to tolerate CPAP and has tried CPAP)
7. **Only Diagnostic Sleep Study**
8. **Multiple Sleep Latency Test (MSLT)/ Multiple Wakefulness Test (MWT)** will need Sleep Study prior night with or without CPAP. Will need prior consultation by Dr. Gill.
9. **Pulmonary Consult Only** – Reason for consult: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAX THIS FORM TO (530)749-9259 WITH THE FOLLOWING INFORMATION:**

1. **Copy of insurance card**
2. **Patient demographic information**
3. **Clinical notes relating to sleep disorder**

Ajaipal S Gill MD Inc. may obtain insurance authorization and schedule the patient, if all clinical information is available.

**ORDERING PHYSICIAN INFORMATION**

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that to the best of my knowledge, this test and any interpretation is medically necessary in order to provide information which will assist in the proper diagnosis and/or treatment for the above named patient.