We accept all PPO and Tricare referrals

Everestsleepcenter.com
Phone or Text: (562) 291-2191
Fax: (562) 291- 2858
Email: orders@everestsleepcenter.com
Locations:

Downey(HST/OAT)
Orange(HST/In-Lab)
Long Beach(HST/In-Lab)

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Height : _____ Weight: _____ Neck Circumference: _____ Age: _____

Please Provide ☐ Demographics ☐ Insurance Card ☐ Chart Notes

Consult: ☐ Consultation with Specialist	**Imaging:** ☐ CBCT (70486)
Treatment: ☐ Oral Appliance Therapy (E0486) ☐ PAP Therapy ☐ CPAP ☐ APAP ☐ BiPAP ☐ ASV ☐ Inspire Therapy	**Sleep Testing:** ☐ Home Sleep Test (95806 / 95800 / G0399) ☐ Baseline Diagnostic PSG (95810)*Convert to HST if required ☐ PAP Titration Study (95811) ☐ CPAP ☐ BiPAP ☐ ST/ASV ☐ Split Night Study (95811) *Convert to HST if required ☐ Efficacy Home Sleep Test (95806 / 95800 / G0399)

Diagnosis, Please mark all that apply:	**Please provide additional Details & Diagnosis:**		
☐ Diagnosed or Suspected OSA (G47.33) **AHI:** _____ **RDI:** _____ ☐ Parasomnia (G47.50) ☐ PLM / RLS (G47.61) ☐ Excessive Daytime Sleepiness (G47.10) ☐ Snoring Habitual (R06.83) ☐ Primary Central Sleep Apnea (G47.31) ☐ Other: _____	1. Witnessed Apnea 2. Excessive Daytime Sleepiness 3. Is snoring observed or diagnosed 4. Diagnosed hypertension 5. Restless limbs while sleeping 6. Trouble staying asleep or falling asleep	Yes / NO Yes / NO Yes / NO Yes / NO Yes / NO Yes / NO Total	8 4 4 2 3 4 ___

Physician Name: _____ NPI: _____

Address: _____ City/State: _____ ZIP: _____

Phone: _____ Fax: _____ Practice Name: _____

Contact: _____ Email: _____

I have placed this order based on a comprehensive sleep evaluation for this patient and have determined that this patient has a high pretest probability of obstructive sleep apnea (OSA).

Signature: _____ **DATE:** _____ DA

Please Fax Order to (562) 291-2858 or email to orders@everestsleepcenter.com