PENINSULA
SLEEP CENTER

Medical Office
1720 El Camino Real, Ste. 105
Burlingame, CA 94010
Phone: (650) 779-4055
Fax: (650) 777-9111

Sleep Study Order Form

Patient Name:_____ **Referring Physician:** _____

Reason for study: _____

_____

Significant history or symptoms: _____

_____

Requested service:

☐ **Sleep medicine consultation**

☐ **Sleep study only:**
(Interpretation and recommendations included. No consultation unless checked above)

- ☐ *Diagnostic sleep study*
- ☐ *Sleep study to determine the optimum CPAP/BiLevel pressures.* *(Previously diagnosed OSA)*
- ☐ *Split night (Half diagnostic, half CPAP titration.)*
- ☐ *Home sleep apnea testing*

☐ **Oral appliance consultation and fabrication:** *(treatment of OSA, provided by sleep dentists)*

☐ **CPAP/ BiPAP machine and its mask**

☐ **Other:** _____

Special instructions if any: _____

_____

I certify that I have seen this patient in person and have discussed sleep-related symptoms with the patient and the above is medically necessary.

Ordering Physician's Signature: _____ Date: _____

Please fax this form and below information to (650) 777-9111

[ ] Current clinical notes
[ ] Patient demographics and copy of insurance card.

Thank you for your referral