Metroplex Health System
A PARTNER WITH SCOTT&WHITE HEALTHCARE

Metroplex Hospital Sleep Center
2111 S. Clear Creek Rd., Killeen, TX 76549
Ph: 254.519.8452 Fax: 254.519.8322

Physician Order/Referral Form

Patient Name: _____ DOB: _____

Phone: _____ SSN: _____

Referring Physician: _____

Physician Phone: _____ Fax: _____

Indication for Testing: _____

Diagnosis (ICD-10): _____

Please choose one of the following options:

☐ **Option 1:** Refer to Board Certified Sleep Physician to do consultation for diagnosis, prescribing treatment and performing clinical follow-up.

☐ **Option 2:** Ordering Physician will prescribe testing, receive report, prescribe treatment and perform clinical follow-up. If choosing this option, please check procedure to be performed.

O Diagnostic Polysomnogram O CPAP Titration

O Multiple Sleep Latency Test (MSLT) O Diagnostic Polysomnogram followed by MSLT

Authorization # : _____

Physician Signature: _____ Date: _____

Please list any patient needs that are required (O2, wheel chair, etc.): _____

_____

Required Patient Data:

1. Physician signed History and Physical (if within the past 30 days) **OR** last office note of patient medical history/exams.
2. Insurance Information
3. Previous sleep reports from other facilities if available/applicable.