NORTHSHORE
SLEEP MEDICINE

SLEEP EVALUATION REQUISITION

PATIENT REFERRAL FORM

Please fax this requisition to the sleep center at 847-674-3639 or 224-235-4895.

Physician

Address

Phone

Fax

MACRA-Designated Email

INSURANCE

We accept insurance from the following groups.

- Aetna
- BlueCross BlueShield PPO
- Blue Choice PPO
- Cigna/Great West Healthcare
- Humana
- Medicare
  (and all secondary and supplemental plans, as well as Medicare Advantage and Medicare Replacement plans)
- United Healthcare
- Multiplan/PHCS

We are not in network with Medicaid nor most HMOs.

IF YOU PREFER TO SEND YOUR REQUISITION BY EMAIL, please use our MACRA-designated email and send to:

- muhammad.najjar@directaddress.net
  or
- roukan.jazayerli@directaddress.net

PATIENT INFORMATION

Patient Name

Phone

Date of Birth

PROVISIONAL DIAGNOSIS

- ☐ Obstructive Sleep Apnea
- ☐ Insomnia
- ☐ Restless Legs / Periodic Limb Movements
- ☐ Hypersomnia
- ☐ Narcolepsy
- ☐ Other: _____

SERVICE REQUESTED

- ☐ Sleep Evaluation Consultation
- ☐ Diagnostic Sleep Study
- ☐ Home Sleep Study
- ☐ Titration of Nasal CPAP/BIPAP
- ☐ Insomnia Evaluation and Treatment
- ☐ DME Referral

Physician Signature

When indicated, supplemental oxygen will be delivered by protocol and the referring physician will be notified following the study.

Sleep better with expert care.