PEARL CLINIC

Prescription Form & Certificate of Medical Necessity

Fax completed form, a recent H&P, demographics, any previous studies and a copy of insurance cards to:
(302) 648-2097

Patient Name: _____ DOB: _____ Sex: _____

Address: _____

Phone Number(s) : _____

Soc. Sec. # : _____ Height: _____ Weight: _____

Primary Insurance and Phone # : _____

Presenting Symptoms: **(mark all that apply)**

☐ Snoring ☐ Witnessed Apnea ☐ Excessive Daytime Sleepiness ☐ Unrefreshing sleep
☐ Morning Headache ☐ Awakens chocking/gasping ☐ Awakens with dry mouth/sore throat
☐ Insomnia ☐ Near miss/car accident ☐ Restless legs/cramps/jerks ☐ Decreased memory
☐ Cataplexy/Hypnogogic hallucinations ☐ Grinding teeth ☐ Falls asleep inappropriately

Past Medical History: **(mark all that apply)**

☐ Obesity ☐ HTN ☐ CAD ☐ Cardiac arrhythmia ☐ COPD/asthma ☐ Stroke/TIA
☐ Diabetes ☐ Seizure ☐ Hypoventialtion Syndrome ☐ Pul. HTN ☐ GERD
☐ Upper Airway Resistance ☐ Cognitive Impairment

Suspected Sleep Diagnosis: **(mark all that apply)**

☐ Obstructive Sleep Apnea (327.23) ☐ Insomnia w/ sleep apnea (780.51)
☐ Restless leg syndrome (333.94) ☐ Narcolepsy (347) w/ cataplexy (347.01)
☐ Hypersomnia with sleep apnea (780.53)

Sleep Study Prescribed:

☐ Home sleep study (95806)
☐ Current CPAP/BIPAP level needs re-evaluation Current Setting: _____
☐ Consult sleep physician for evaluation and treatment

Referring Physician Name : _____

Signature : _____ Date: _____

Phone # : _____ Fax # : _____