NEUROLOGICAL REFERRAL SCRIPT

Patient's Name _____ DOB_____ Patient Address_____

Primary Insurance Secondary Insurance

___ Sleep Study (Insomnia)

__ F51.03 Hyposomnia / Insomnia
Paradoxical insomnia - sleep state misperception or pseudo insomnia

__ F51.09 Insomnia - not due to a substance or known physiological condition
Hypersomnia

__ G47.11 Idiopathic hypersomnia with long sleep time

__ G47.12 Idiopathic hypersomnia without long sleep time

__ G47.08 Other sleep disorder or disturbances – due to general medical or mixed condition, or sleep onset disorder

__ R53.83 Other fatigue – lack of energy or tiredness
Hypersomnia with comorbid depression

__ F51.12 Insufficient sleep syndrome – insufficient sleep excludes sleep deprivation

__ F51.19 Hypersomnia – non-organic and not due to a substance or known physiological condition
Sleep quality potentially impacted by mental state

__ F41.09 Anxiety - chronic
Memory potentially impacted by sleep quality

__ G31.84 Mild cognitive impairment

Based on the patient's examination, diagnosis, and history, it is my professional opinion that these tests are medically necessary for the diagnosis and treatment.

Physician's Signature:_____ Physician's Name: _____Date:_____