

Referring Provider: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address \_\_\_\_\_ PCP Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_ MRN# \_\_\_\_\_

DOB: \_\_\_\_\_ Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Will a supplied interpreter be needed for this appointment?  No  Yes Language: \_\_\_\_\_

Health Insurance: \_\_\_\_\_ Subscribers Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group# \_\_\_\_\_ Subscribers DOB \_\_\_\_\_

## Referral for Sleep Disorders Center

### Reason for referral:

Prior PSG:  No  Yes When \_\_\_\_\_ (please forward copy) Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### Signs and symptoms: (check all that apply)

- Observed apnea     Daytime sleepiness     Snoring     CHF     Periodic limb movements     Insomnia
- Restless legs     Morning headaches     COPD     High BP     Parasomnia (e.g. sleepwalking)

### Medical conditions:

Using Oxygen:  No  Yes \_\_\_\_\_ lpm  Nighttime  Continuous  Tracheotomy

Physically disabled:  No  Yes (explain) \_\_\_\_\_

Developmentally disabled:  No  Yes (explain) \_\_\_\_\_

Other medical conditions: \_\_\_\_\_

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### Please attach with this form:

- Medication list     Previous office notes for sleep issues     Previous Sleep Study Records