

### PATIENT REFERRAL

Date \_\_\_\_\_ Diagnosis (ICD 9 Code) \_\_\_\_\_

Prior sleep testing?  YES  NO If yes, please send previous study.

### PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  Male  Female

Social Security Number \_\_\_\_\_ Date Of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### REFERRING PHYSICIAN (Please Print)

Name \_\_\_\_\_ Staff Contact Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

UPIN \_\_\_\_\_

**PLEASE INCLUDE THE FOLLOWING. AN APPOINTMENT CANNOT BE MADE WITHOUT THE FOLLOWING INFORMATION. THANK YOU.**

- |  |   |
|--|---|
| <input type="checkbox"/> Orders including Diagnosis Code | <input type="checkbox"/> Demographics                       |
| <input type="checkbox"/> Copy of Insurance Card(s)       | <input type="checkbox"/> Copy of Drivers License            |
| <input type="checkbox"/> History and Physical            | <input type="checkbox"/> Recent Dictation                   |
| <input type="checkbox"/> Medication list                 | <input type="checkbox"/> Previous sleep study if applicable |

### STUDIES REQUESTED

- PSG + CPAP titration (standard sleep study)
- PSG (diagnostic study only)
- CPAP titration (therapeutic study only)
- MSLT (multiple sleep latency test) will be preceded with a PSG study
- MWT (maintenance of wakefulness test)
- Other \_\_\_\_\_

The patient may take their own medications as listed in the history and physical or medication reconciliation. Consultation with a sleep physician to evaluate the patient's sleep, review results with patient, initiate therapy and monitor the patient's progress and compliance will be provided unless otherwise indicated. We find this improves patient success.

Signature of Ordering Physician \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ AM PM  
Circle One