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SLEEP MEDICINE CONSULT

Please fax office note, demographic information and both sides of the insurance card.

PATIENT INFORMATION RECORD TODAY'S DATE ____________________

____
Last Name First Middle

____
Home Address

______________________ ______________________ ________________@______________
Cell Phone Home Phone Email

_____/________/________ ________ ________ _______-_____-________
Date Of Birth Age Sex SSN

____
MEDICAL INSURANCE POLICY # GROUP #

REFERRING PHYSICIAN INFORMATION

______________________________ ____
Physician Name Address

______________________ ______________________ ______________________
Office Phone Office Fax Preferred Contact Method

______________________ ______________________ ________________@______________
Office Contact Name Office Contact Phone Office Email

SLEEP DIAGNOSIS/INDICATIONS *(must check at least one of the following)*

- ☐ Obstructive Sleep Apnea G47.33
- ☐ Sleep Apnea, unspecified G47.30
- ☐ Fatigue R53.83
- ☐ Snoring R06.83
- ☐ Hypersomnia, other G47.10
- ☐ Hypersomnia, unspecified G47.19
- ☐ Insomnia with Sleep Apnea G47.01
- ☐ Adjustment Insomnia F51.01
- ☐ Other Sleep related disorders G47.8
- ☐ Other__________________________

EXCLUSION CRITERIA (For a home sleep test, none of the following co-morbid conditions can be present.)
Patient does NOT have any of the following diagnoses Congestive Heart Disease (moderate or severe), Chronic Pulmonary Disease, Hypoventilation conditions, sleep related movement disorder or immobility/physical limitations.

PHYSICIAN ORDER (please check one)

- ☐ Referral for Evaluation of Sleep Related Disorders
- ☐ Referral for Evaluation and Continued Management of Sleep Related Disorders
- ☐ Referral for Evaluation of Sleep Apnea and Home Sleep Study
- ☐ Referral for Evaluation and Continued Management of Sleep Apnea and Home Sleep Study