SLEEP CONSULTATION/REFERRAL REQUEST FORM

Referring Physician

Name: _____

Address:_____

_____

Phone: _____

Fax: _____

Email: _____

To: Valiulis Sleep Clinic
Dr. Mary Beth Valiulis
7607 Fern Ave, Ste 204
Shreveport, LA 71105
Phone/Fax: (318) 797-3350
Fax: (318) 797-3353
www.valiulis.com

SECTION 1 – REQUESTED ACTION

Consultation
(Please send the patient back for follow-up and treatment.)
☐ Confirm diagnosis/suggest medicine or treatment
☐ Advise as to diagnosis / suggest medicine or treatment

Referral
(Please provide summaries to referring physician as appropriate.)
☐ Assume management of this condition and return patient after conclusion of care
☐ Assume future management of patient within your area of expertise

SECTION 2 – PATIENT INFORMATION

Name: _____ Date of Birth: _____
Address: _____
Home Phone: _____ Cell Phone: _____ Email address: _____
Tentative Diagnosis: _____ ICD-10:_____

Please fax: (1) recent office notes with clinical indication; and (2) copy of insurance card(s)

☐ Clinical concern for sleep apnea
☐ Excessive daytime sleepiness/Fatigue
☐ Difficulty initiating or maintaining sleep
☐ Restless legs syndrome
☐ Abnormal behavior during sleep
☐ Sleep apnea, unspecified
☐ Insomnia with sleep apnea, unspecified
☐ Insomnia
☐ Narcolepsy
☐ Parasomnia
☐ Hypersomnia
☐ RLS/PLMS
☐ Period limb movement disorder
☐ Sleep related movement disorder, unspecified
☐ Snoring
☐ Circadian rhythm sleep disorder

Pertinent history, physical exam, laboratory findings, and other special considerations:

☐ See additional information attached
☐ I would like to receive periodic status reports on this patient as you deem appropriate.
☐ Please send me a report when the consultation is complete.
☐ I would like to receive periodic status reports on this patient.

Referring Physician:

Sign: _____ Date: _____

Print name: _____