Referral for Sleep Disorder Consult

Referring Physician Office:

Please call our office at 488-2636 to obtain appointment time.
Fax completed form to our office at 331-2617
Fax or mail relevant information
(Previous lab studies – thyroid status, iron studies, metabolic panel etc.)
Give patient the form. You may keep a copy for your records.

Referring Physician: ______________________________ Phone # _________________

Patients Name: ___________________________________ DOB: ____________________

Home / Message phone: ___________________

Primary Insurance Company: ______________________ ID #: __________________

Secondary Insurance Company: ____________________ ID#: __________________

Reason for Referral (Check all that apply)

☐ Loud Snoring
☐ Insomnia
☐ Daytime Fatigue
☐ Witnessed Sleep Apnea
☐ Non Restoring Sleep
☐ Restless Legs
☐ Diagnosed Sleep Apnea
☐ Daytime Sleepiness
☐ Shift Work Related

Other (please specify) ____

Patient:
Your appointment is scheduled at Othello Community Sleep Center
On ___________________________ at ____________________________________
Date Time
Please bring your insurance card(s) and applicable co-pay at the time of visit.