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PATIENT REFERRAL FORM

Fax or securely email this form with any records being provided.

1. PATIENT INFORMATION

Patient name (Last, First, M.I.) **Date of birth**

Preferred phone **Email**

Address **City / State / ZIP**

Medical insurance **Member / policy ID** **Medicare?** ☐ Yes ☐ No

2. REFERRING PROVIDER

Referring provider **Practice name**

Phone **Fax** **Secure email**

3. PRIMARY REASON FOR REFERRAL

Please select the primary reason for this referral:

☐ Sleep-testing evaluation ☐ Oral-appliance evaluation

☐ CPAP-alternative evaluation ☐ Other: _____

Relevant symptoms, concerns, or special instructions (optional)

4. RECORDS INCLUDED

☐ Sleep study/report ☐ Clinical notes

☐ Patient demographics ☐ Insurance card — front and back

☐ Please request records from our office ☐ No records available at this time

Referring provider signature **Date**

Thank you for your referral. We will contact the patient and keep your office informed.