Sleep Center

Referral Request

PATIENT INFORMATION

Last Name: ______________________ **First Name:** ______________________ **MI:** ________

Phone: ______________________________________ Date of Birth: ____________

ICD-9(s) for diagnosis or symptoms: ______________________________________

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Physician Signature: ______________________________ **Date:** ____________

Printed Name: ______________________ cc to: __________ : ______________

BOLDED ELEMENTS ARE REGULATED REQUIREMENTS

☐ Please call patient to schedule exam

Insurance: ______________ Member ID Number: __________ Authorization Number: __________

Prior Related Studies: ☐ Yes ☐ No Location: ______________ Interpreter Needed: ☐ Yes ☐ No

☐ *Patient is at risk for falls; please use precautions per protocols*

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CLINICAL INDICATIONS FOR REFERRAL

☐ Excessive Daytime Sleepiness ☐ Snoring ☐ Sleep Apnes

☐ Periodic Limb Movement ☐ Nocturnal Hypoxemia ☐

☐ Other: ______________________________________

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EXAM

☐ Sleep Disorders Evaluation and Treatment ☐ Overnight Pulse Oximetry

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PLEASE COMPLETE THIS FORM AND FAX ALONG WITH CHART NOTES.

Your patient will be contacted and scheduled for evaluation. A patient sleep questionnaire and related materials will be mailed to the patient.

Thank you for choosing Salem Health's Sleep Center.

Sleep Center
890 Oak St. SE - Building C, Suite 3040
Salem, OR 97301
Phone: 503-561-5170
Fax: 503-561-4709

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