

Pulmonary and Sleep

Referral Request



PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Phone: _____ Date of Birth: _____

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

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

CLINICAL INDICATIONS FOR REFERRAL

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Snoring | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Periodic Limb Movement | <input type="checkbox"/> Nocturnal Hypoxemia | <input type="checkbox"/> |
| <input type="checkbox"/> Other: _____ | | |

EXAM

- Sleep Disorders Evaluation and Treatment Overnight Pulse Oximetry

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 Pulmonary and Sleep.