Sleep Center
Referral Request

Salem Hospital
A part of Salem Health

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: Y N Location: _____ Interpreter Needed: ☐ Y ☐ N

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

Clinical Indications for Referral:

☐ **Excessive Daytime Sleepiness** ☐ **Snoring** ☐ **Sleep Apnea**

☐ **Periodic Limb Movement** ☐ **Nocturnal Hypoxemia** ☐ **Insomnia**

☐ **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 Hospital's Sleep Center.

AMERICAN ACADEMY OF SLEEP MEDICINE
WAKE SLEEP
ACCREDITED MEMBER CENTER

Scheduling: 503-561-5170 **Fax consult request to: 503-561-4709** **To reorder form, call: 503-561-3778**

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