REFERRAL FORM

Please complete this form and return with **demographics** and **chart notes** by fax.

We will contact the patient to schedule the study that you have ordered. This is not an insurance referral.

515 W. Forest St. Suite B1
Brigham City, Utah 84302

(T): 435-723-0868
(F): 435-723-0861

(F): 435-292-7077

Patient Information

Name: ______________________________ **DOB:** ______________________
Address: ______________________________ **Sex:** ☐ **Male** ☐ **Female**
City, State, Zip: ______________________________
Phone: ______________________________

Insurance: ______________________________
Policy ID: ______________________________

Referring Physician

Physician Name: ______________________________
Physician number: ______________________________ **NPI:** ______________________
Fax: ______________________________ **Office Contact:** ______________________

Sleep Center Testing

☐ **Home Sleep Study**

Diagnosis

☐ **Hypertension**	☐ **Hypoxia**	☐ **OSA**	☐ **Other**
☐ **CHF**	☐ **Sleep Disturbances**	☐ **CSA**	______________________
☐ **COPD**	☐ **Snoring**	☐ **Diabetes**	
☐ **Fatigue**	☐ **Insomnia**	☐ **Cardiac Arrythmia**	

Special Instructions: ______________________________

Physician Signature: ______________________________