National Jewish Health®
Science Transforming Life®

SLEEP CENTER REFERRAL FORM

Phone 303-270-2708 Fax 303-270-2109

Main Campus	*Broomfield Campus*	*DTC Campus*
1400 Jackson St	480 Flatiron Blvd	7877 S. Chester St.
Denver, CO 80206	Broomfield, CO 80021	Englewood, CO 80012

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____ Gender: ☐ M ☐ F

DOB _____ SS# _____ Marital Status ☐ S ☐ M ☐ D ☐ W

Street Address: _____ Apt/PO _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

PRIMARY INSURANCE _____ ID# _____ Group _____

Address _____ Phone _____

Subscriber _____ Guarantor _____ DOB _____

Employer _____

SUSPECTED DISORDERS: (Check all that apply)

☐ Narcolepsy ☐ Nocturnal Seizures/Parasomnias ☐ Periodic Limb Movements of Sleep (PLMS) ☐ Obstructive Sleep Apnea Syndrome (OSAS)

☐ Insomnia ☐ Other: _____

THIS PATIENT IS BEING REFERRED FOR: (Please check all that apply)

☐ Sleep Consultation with Sleep Study Sleep Specialist Consultation for evaluation, diagnostic testing and treatment.

☐ Clinic Consultation

☐ Sleep Study

☐ Multiple Sleep Latency Test following Overnight Sleep Study

☐ Maintenance of Wakefulness Test

All testing will adhere to American Academy of Sleep Medicine Practice Parameters. For medical documentation and to satisfy insurance guidelines for reimbursement, adequate baseline data and sleep time will be collected before attempting treatment intervention. Split-night studies will be performed whenever appropriate.

RELEVANT MEDICAL HISTORY: (Please forward most recent history and physical)

Medications _____

Primary Symptoms ☐ Witnessed apneas ☐ Frequent snorning ☐ Daytime sleepiness ☐ Difficulty falling asleep ☐ Frequent leg movements during sleep ☐ Obese / Large neck

Comments _____

_____

Special Needs ☐ Nocturnal O2 ☐ Wheel Chair ☐ Interpreter ☐ Other: _____

Primary Care Physician: _____ Phone _____ Fax _____

Referring Physician:

Print Name: _____ Phone _____ Fax _____

Address _____ Reports will be sent here

UPIN #: _____ TAX ID: _____ Group Name: _____

Signature: _____ Date: _____ NPI #: _____