

SLEEP CENTER REFERRAL FORM

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

Main Campus
1400 Jackson St
Denver, CO 80206

Broomfield Campus
480 Flatiron Blvd
Broomfield, CO 80021

DTC Campus
7877 S. Chester St.
Englewood, CO 80112

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 snoring 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 #: _____