

Main Campus
 1400 Jackson St
 Denver, CO 80206

**SLEEP CENTER
 REFERRAL FORM**

Office #: 303-270-2708
 Fax #: 303-270-2109

Littleton Campus
 1510 W Mineral Ave
 Littleton, CO 80120

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 _____

Secondary Insurance

_____ ID# _____ Group _____
 Address _____ Phone _____

Next of Kin/Emergency _____ Relationship _____ Phone _____

(For Sleep Center Use)

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)

- Clinic Consultation One time visit with a Sleep specialist to assist in the evaluation of this patient for testing.
- Clinic Consultation One time visit with a Sleep specialist to follow up with this patient after sleep testing.
- Sleep Study Provide a full night sleep study; Diagnostic with PAP titration if indicated.
- Multiple Sleep Latency Test Follow nighttime test with daytime nap testing for Narcolepsy, or other, diagnosis
- Maintenance of Wakefulness Test Follow nighttime testing with daytime naps to determine vigilance
- CPAP / BiPAP Set-Up Provide CPAP or BiPAP treatment and equipment if indicated by Sleep Study

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: _____

Referring Physician:
 Print Name: _____ Phone _____ Fax _____
 Address _____ Reports will be sent here
 UPIN #: _____ TAX ID: _____ Group Name: _____
 Signature: _____ Date: _____