SleepEz Patient Referral Form

Complete this form to refer a patient for sleep medicine services

Referring Provider Information

Provider Name *

NPI Number *

Specialty

Practice Name *

Phone *

Fax

Email

Address

Patient Information

Patient Name *

Date of Birth *

Gender

Phone *

Email

Address

Primary Insurance

Insurance ID

Group Number

Secondary Insurance

Insurance ID

Group Number

Referral Information

Reason for Referral (check all that apply): *

- ☐ Suspected OSA
- ☐ Insomnia
- ☐ Narcolepsy
- ☐ Restless Leg Syndrome
- ☐ PAP Therapy Management
- ☐ Other

Additional Notes/Clinical Information:

Services Requested

- ☐ Sleep Consultation
- ☐ Home Sleep Test
- ☐ In-lab Polysomnography
- ☐ PAP Therapy
- ☐ Remote Monitoring
- ☐ Other

Patient Symptoms

- ☐ Snoring
- ☐ Gasping/Choking
- ☐ Witnessed Apneas
- ☐ Insomnia
- ☐ Daytime Sleepiness
- ☐ Fatigue
- ☐ Morning Headaches
- ☐ Nocturia

Duration of Symptoms

Epworth Sleepiness Score (if known)

BMI (if known)

Relevant Medical History

- ☐ Hypertension
- ☐ Atrial Fibrillation
- ☐ CHF
- ☐ CAD
- ☐ Stroke/TIA
- ☐ Diabetes
- ☐ Obesity
- ☐ Asthma
- ☐ COPD
- ☐ Depression
- ☐ Anxiety

Current Medications:

Allergies:

Previous Sleep Study? (Yes/No/Unknown)

If yes, approximate date

Previous PAP Therapy? (Yes/No/Unknown)

Signature

Referring Provider Signature *

Date *

Fields marked with * are required

Please fax completed form to: (844) 787-4672 or email to: referrals@sleepez.com