THE SLEEP CLINIC

Patient Referral Form

Name: _____ Email Address: _____

Address: _____City: _____ State: _____ Zip: _____

Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security Number: _____

Ordering MD: _____ Phone: _____ Fax: _____

Interpreting MD: _____ Phone: _____ Fax: _____

Diagnosis and Recommended Evaluation Protocols

Please check appropriate order.

Consultation: _____ Evaluation, treatment and follow up by sleep physician as appropriate.

Sleep Apnea: _____NPSG_____PSG _____ CPAP Titration

Hypnotic and dose to be used with titration if appropriate: _____, _____mg

Snoring: _____ NPSG_____ PSG

Excessive Daytime Sleepiness: _____NPSG and Multiple Sleep Latency Test (MSLT)

Narcolepsy: _____NPSG and Multiple Sleep Latency Test (MSLT)

In order to obtain authorization for the sleep study, a History and Physical Exam documenting indications for the study need to be faxed. Indication examples include, snoring, witnessed apnea, hypertension, excessive daytime sleepiness, abnormal behavior during sleep….etc.

Insurance Information

Insurance: _____ Insurance Phone Number: _____

Policy Holder: _____ ID Number: _____

Physician's Signature: _____ Date: _____

Thank you for your referral! Please FAX this form and the H&P to 318.797.6077

Nabil A. Moufarrej, MD, FAASM • 2205 E. 70th St, Shreveport, LA 71105 • Phone: 318.797.1585 Fax: 318.797.6077
www.sleepcliniconline.net