

SELECT LOCATION BELOW:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Plano
Ph: 972.473.7300
6313 Preston Rd, #400
Plano, TX 75024 | <input type="checkbox"/> Dallas
Ph: 469.726.2208
11617 N. Central Expy, #250
Dallas, TX 75243 | <input type="checkbox"/> McKinney
Ph: 972.473.7300
8000 W. Eldorado Pkwy., Ste B, Bldg C
McKinney, TX 75070 | <input type="checkbox"/> Keller
Ph: 972.473.7300
8865 Davis Blvd., Ste 100 A
Keller, TX 76248 |
|---|---|---|---|

PATIENT INFORMATION

Name _____ Home Phone _____ DOB _____
Street Address _____ Cell/Work Phone _____ M/F _____
City, State, Zip _____ Email address _____
Insurance _____ Insurance ID # _____
Subscriber _____ SS # _____

▶ **FOR ALL REFERRED PATIENTS, PLEASE SEND COPY OF INSURANCE AND DEMOGRAPHICS.
FOR PATIENTS REFERRED FOR SLEEP STUDY ONLY, A RECENT H&P OR MEDICAL PROGRESS NOTE IS ALSO REQUIRED.**

EVALUATION AND TREATMENT (Check only one box)

Consultation and Management with sleep studies as needed

**Medicare insured patients are required to be seen in office prior to any sleep studies.
For MSLT evaluation, a Consultation is required prior to any sleep study evaluation.**

Sleep Study Only (results are sent to referring physician for further management)

All referrals for sleep study only are required to include progress notes documenting need for sleep study evaluation.

- Diagnostic sleep study - Full Night In-Lab Polysomnography (PSG)
 Home Screening for Apnea (HSA)
 Split Night Sleep Study -- Full Night In-Lab Polysomnography, with 1/2 PSG and 1/2 CPAP, IF criteria are met

REFERRAL CHECK LIST (All boxes must be checked and info included)

- Recent Progress Notes
 Insurance Card
 Patient Demographics

REFERRING PHYSICIAN INFORMATION

Name _____ Phone _____
Street Address _____ Fax _____
City, State, Zip _____
▶ Physician's Signature _____ Date _____