

TEXAS NEUROLOGY

SLEEP DISORDERS CENTER REFERRAL FORM

CONSULT WITH SLEEP STUDY

SLEEP STUDY ONLY ROUTINE MSLT CPAP/BiPAP SPLIT STUDY

Please complete this form in its entirety to expedite your patient referral to the TEXAS NEUROLOGY SLEEP DISORDERS CENTER.

Fax the completed form and a copy of the patient's insurance card(s) to **(214) 443-5194**.

A confirmation of the appointment will be sent to your office.

You may check status with the Sleep Coordinator directly at **(214) 443-5154**.



PATIENT INFORMATION: (PLEASE PRINT)

NAME: _____ DOB: _____ SSN: _____

ADDRESS: _____

SEX: M F HOME PHONE: _____ WORK PHONE: _____

PHYSICIAN INFORMATION:

PHYSICIAN NAME: _____ PHYSICIAN NPI: _____

CONTACT PERSON: _____ CONTACT NUMBER: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

INSURANCE INFORMATION: MEDICARE MEDICAID HMO PPO POS EPO OTHER

PRIMARY INSURANCE CARRIER: _____

PHONE#: _____ PRECERT#: _____

MEMBER ID: _____ GROUP#: _____

SECONDARY INSURANCE CARRIER: _____

PHONE#: _____ PRECERT#: _____

MEMBER ID: _____ GROUP#: _____

WORKING DIAGNOSIS/ICD-9 CODE(S): _____

CLINICAL OBSERVATIONS/INDICATIONS:

- | | | |
|--|--|---|
| <input type="checkbox"/> WITNESSED APNEA | <input type="checkbox"/> DAYTIME FATIGUE | <input type="checkbox"/> RESTLESS SLEEP |
| <input type="checkbox"/> HYPERTENSION | <input type="checkbox"/> FREQUENT NAPPING | <input type="checkbox"/> SNORING |
| <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> MORNING HEADACHES | <input type="checkbox"/> POOR MEMORY |
| <input type="checkbox"/> OBESITY | <input type="checkbox"/> OTHER: _____ | |

COMMENTS: _____

TEXAS NEUROLOGY OFFICE USE ONLY

SCHEDULE DATE: _____ ARRIVAL TIME: _____ APPOINTMENT TIME: _____

THANK YOU FOR YOUR REFERRAL!