Sleep Consult Request

Fax order to: **952-345-4508**

MINNESOTA SLEEP INSTITUTE
Accredited by the American Academy of Sleep Medicine

Today's Date:		
☐ **Adult** Sleep Disorders Center (ages 19 and older)	☐ **Pediatric** Sleep Disorders Center (ages 8-18)	☐ **Insomnia** Program

PATIENT INFORMATION

Patient Name:

Address:	**Phone:** Cell: Home/Work:

Birth Date:	**Sex:** F☐ M☐	**Insurance Carrier:** (Attach copy of card) Primary: Secondary:

REASON FOR REFERRAL

☐ Sleep Apnea	☐ Restless Leg	☐ Witnessed Apnea
☐ Sleep Walking/Nightmares	☐ Narcolepsy	☐ Cardiac Disease
☐ Sleepiness	☐ Obesity	☐ Other:
☐ Nocturia	☐ Snoring	

CLINIC INFORMATION

Referring Clinic:	**Contact Person:** Name:
Referring Provider:	Fax: Phone:

Sleep Procedure Scheduling

Phone: 952-567-7412
Fax: 952-345-4508

☐ **I want to be notified of appt date/time.**

Apt Date_____Time_____

☐ Pt declined apt
☐ Unable to contact patient