MINNESOTA SLEEP INSTITUTE
Accredited by the American Academy of Sleep Medicine

Sleep Consult Request
From Dental Clinic

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

DATE OF REQUEST:			
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:			
CLINIC INFORMATION			
Referring Clinic: **Referring Provider:**	**Contact Person:** Name: Fax: Phone:	☐ **I want to be notified of appt date/time.** ☐ Fax ☐ Phone	

Sleep Procedure Scheduling
Phone: 952-567-7412
Fax: 952-345-4508

Apt Date_____Time_____

☐ Pt declined apt
☐ Unable to contact patient

June 2011