

Fast Track

for Sleep Study



Accredited by the American Academy of Sleep Medicine

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

PATIENT INFORMATION		
Date of request:	Birth Date:	
Patient Name:	Sex: F <input type="checkbox"/> M <input type="checkbox"/>	
Address:	Cell:	Other:
Insurance Carrier: (Attach copy of card) Primary: Secondary:		Note: Medicare requires consult before study.
REASON FOR REFERRAL		
<input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Sleep Walking/Nightmares <input type="checkbox"/> Sleepiness <input type="checkbox"/> Nocturia	<input type="checkbox"/> Restless Leg <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Obesity <input type="checkbox"/> Witnessed Apnea	<input type="checkbox"/> Snoring <input type="checkbox"/> Cardiac Disease <input type="checkbox"/> Other:
CLINIC INFORMATION		
Referring Clinic: Referring Provider:	Contact Person: Name: Fax: Phone:	History and physical dictation <input type="checkbox"/> I am including. <input type="checkbox"/> I will send when available.

Please notify me with apt date/time

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

Apt Date _____ Time _____ <input type="checkbox"/> Pt declined apt <input type="checkbox"/> Unable to contact patient
