

# Referral for Sleep Consultation

Fax referral to: **952-852-2365**

PATIENT INFORMATION			
Patient's Name (First, MI, Last):		Date of Birth (mm/dd/yyyy):	Gender:
Best time to contact patient:	Primary Phone:	Secondary Phone:	
Special instructions:			
Insurance - please include copy of card(s):			
REASON FOR REFERRAL			
Please check all that apply:			
<input type="checkbox"/> Sleep apnea symptoms (e.g. snoring, gasping, choking, witnessed apnea)			
<input type="checkbox"/> Excessive daytime sleepiness <input type="checkbox"/> Insomnia <input type="checkbox"/> Restless legs <input type="checkbox"/> Sleep walking / talking			
<input type="checkbox"/> Nocturnal seizures <input type="checkbox"/> CHF <input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Inspire® hypoglossal nerve stimulator consultation			
<input type="checkbox"/> Other: _____			
REFERRING PROVIDER			
Date:	Your clinic name:	Provider (first, last, degree):	
Clinic contact person:	Phone:	Fax:	
Comments / Special instructions:			
Contact us: <b>Phone: 952-567-7412</b> <b>Fax: 952-852-2365</b>  Burnsville    Edina    Minneapolis    Plymouth    Woodbury			