Innovative SLEEP CENTERS

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Sleep Referral Form

Please fax this referral form with the following documents:

- ☐ **Patient demographics**
- ☐ **Copy of Current Insurance Cards**
- ☐ **Clinical notes; Progress notes, Labs**
- ☐ **Echocardiogram**

Patient Name	**Date of Birth**
Home Phone #	**Mobile #**
Best time to contact	**Email**

ORDER:

☐ **Consultation** for Sleep Disorder; including:
In-lab testing, Home testing, Durable Medical Equipment (DME), treatment.

MEDICAL NECESSITY:

S.T.O.P. Questionnaire

1. Have you been told that you **S**nore?	☐ Yes	☐ No
2. Do you feel **T**ired?	☐ Yes	☐ No
3. Has anybody **O**bserved you quit breathing during sleep?	☐ Yes	☐ No
4. Are you being treated for high blood **P**ressure?	☐ Yes	☐ No

(Answering Yes to 2 or more questions below indicates 80% chance of having OSA)

Provider Signature: _____ **Date:** _____

Printed Providers Name: _____ **Contact Person:** _____

Office Phone: _____ **Office fax:** _____

Clinic Name:_____ **Clinic Address Location:**_____