

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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Do you feel T ired? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Has anybody O bserved you quit breathing during sleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Are you being treated for high blood P ressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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: _____

www.innovativesleepcenters.com

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