Sleep Life Med
91-3575 Kauluakoko St. #1601, Ewa Beach, HI 96706

Phone: (808) 500-7077 I Fax: (808) 460-3840
hello@sleeplifemed.com | www.sleeplifemed.com

fax to (808) 460-3840

PRACTICIONER REFERRAL FORM

DATE:

PATIENT NAME:

BIRTHDATE:

GENDER:

PHONE & EMAIL:

LANGUAGE SPOKEN:

INSURANCE CARRIER:

ID #:

SUBSCRIBER:

Referral Information:

____ Adult referral ____ Pediatric referral

____ Integrative sleep medicine consultation (evaluation, diagnosis, testing and management)

____ Home sleep apnea test (referring practitioner will provide management for OSA if indicated)

____ Insomnia Therapy (only non-pharmacologic treatment provided)

____ Urgent request (within 2 weeks)

____ High risk occupation (etc. bus driver, pilot)

Diagnosis or symptoms:

____ Suspect obstructive sleep apnea (OSA)

____ Known OSA
____ On continuous positive airway pressure

____ Not on CPAP therapy

____ Discuss alternative therapy

____ Excessive daytime sleepiness

____ Narcolepsy

____ Insomnia

____ Parasomnias (abnormal movements when asleep)

____ Other: _____

REFERRING PRACTICIONER INFORMATION

_____

Referring Practitioner's Address, City, State, Zip

_____

Primary Care Physician (if not referring practitioner)

_____

Referring Practitioner's Phone

_____

Referring Practitioner's Fax

_____

Referring Practitioner's Business Email

_____

Referring Practitioner's Signature

_____

Referring Practitioner's Printed Name

_____

Date