



direct line (808) 500-7077, option 3 fax to (808) 460-3840

CALIFORNIA PRACTICIONER REFERRAL FORM

please include a prior sleep study if available and relevant clinical notes

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)
- Inspire Evaluation
- 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 (include sleep study report)
- Cardiac Hx (HTN, afib, CHF etc.)
- 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