

South County Sleep Disorders Medical Center, Inc.

REFERRAL FORM

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____
Insurance (primary): _____ ID: _____
Insurance (secondary): _____ ID: _____

We do not accept any HMOs or Medi-Cal.

Reason for Request:

- | | |
|--|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Hypertension, pulmonary |
| <input type="checkbox"/> Parasomnia | <input type="checkbox"/> Periodic limb movement |
| <input type="checkbox"/> Sleepiness/Narcolepsy | <input type="checkbox"/> Obstructive sleep apnea |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Dyspnea |
| <input type="checkbox"/> Hypersomnolence | <input type="checkbox"/> Chronic obstructive pulmonary disease |
| <input type="checkbox"/> Fibromyalgia/Chronic Fatigue | <input type="checkbox"/> Abnormal nocturnal breathing |
| <input type="checkbox"/> Erectile dysfunction/Decreased libido | <input type="checkbox"/> Coronary artery disease |
| <input type="checkbox"/> Witnessed Apneas | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other: _____ | |

Medications: _____

Previous Sleep Study: No Yes Date: _____ Location: _____

Notes: _____

Requesting physician: _____ Phone: _____
Address: _____ FAX: _____
City: _____ State: _____ Zip: _____
Signature: _____ Date: _____

Please attach patient's history and physical, chart notes, and copy of insurance card.

Thank you in advance for your request.

2520 Samaritan Drive, Ste. 210, San Jose, CA 95124
9460 No Name Uno, Ste. 220, Gilroy, CA 95020
Phone (408) 356-8900 FAX (408) 356-0974