Sleep Centers OF ALASKA

PATIENT REFERRAL FORM

Patient's Name: _____ Date of Birth: _____ □ Male □ Female

Address: _____ Phone: _____

□ **Initial Consultation:** Comprehensive evaluation of patient for consideration of diagnostic sleep study. Suspicious symptoms suggestive of obstructive sleep apnea include:

- □ Observed apneas
- □ Loud snoring
- □ Excessive daytime sleepiness
- □ Chronic fatigue
- □ Drowsy driving
- □ Falling asleep at inappropriate times
- □ Dry mouth upon awakening
- □ Frequent awakenings
- □ Choking/gasping while asleep
- □ Morning headaches
- □ Prior diagnosis of OSA
- □ Other _____

□ **Re-Evaluation Consultation**: Evaluation of patient for titration polysomnography with oral appliance.
Titration instructions:

_____

_____

Kindly keep me informed of the polysomnography results and my patient's progress.

Dentist's Signature:_____ NPI: _____ Date: _____

Print Name:_____ Phone: _____ Fax:_____

Address: _____

Special Instructions:

_____

Please fax referral form, patient demographics, insurance card, and pertinent clinical notes.

THANK YOU FOR REFERRING YOUR PATIENT TO US!

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