Fax Referral Form

Please complete this form and fax to the PM Sleep Lab location listed below. Our staff of Sleep Professionals will verify insurance, contact the patient and notify you of the scheduled test date.

Date: _______________

Patient Name: ____

Patient Address: ____

Patient Phone: Primary: _____________________________________
Cell or work: __________________________________

Birthday: __________________
S.S. # : __________________
Diagnosis: __________________

Primary Insurance: ______________________ I.D. # _______________

Ordering Physician: __________________________UPIN # ________

Address: ____

Phone: _________________________ FAX: ______________________

Order: Diagnostic Sleep Study __________

Titration Sleep Study ___________

Initiate CPAP/ BIPAP Therapy to treat ______________

Physician signature: __________________________________

FAX to 913-721-5402