2500

PROVIDENCE Health & Services

SLEEP DISORDERS SERVICES

PATIENT IMPRINT

PATIENT LEGAL NAME	DATE OF BIRTH	PATIENT PHONE: H, W, C
INSURANCE NAME	MEMBER / POLICY / ID #	
PHYSICIAN NAME	PHYSICIAN TELEPHONE	PHYSICIAN FAX
SYMPTOMS		ICD 10

Referral to Providence Medford Sleep Program

1111 Crater Lake Ave
Medford, Oregon 97504
Ph: 541-732-7888 Fax: 503-215-2993

❑ Sleep Clinic Referral - Sleep Specialist who will provide consultation, order any necessary testing, or treatment and provide follow-up.

❑ Overnight Oximetry - **CPT 94762** order for overnight oximetry, patient will NOT see sleep specialist.

Please Enclose: *(Required for Accreditation)*

❑ Copy of Insurance Card ❑ H & P &/or Chart Notes, incl. Sleep History ❑ Medications/Allergies

Indications for Referral/Sleep Study:

❑ Snoring	❑ Insomnia	❑ Hypoventilation/Hypercarbia
❑ Observed Apnea	❑ Bariatric Surgery	❑ REM Behavior Disorder
❑ Excessive Daytime Sleepiness	❑ Restless Legs/PLMS	❑ Parasomnia: _____
❑ Retitration CPAP/BiPAP	❑ Hypoxia	❑ Other: _____

Special Instructions:

Physician Signature: _____ **Date:** _____ **Time:** _____