

Consultation only

Direct Referral to Sleep Lab

(Please fill out History and Physical Examination on reverse side)

Referring Physician Name: _____ Phone No: _____ Fax No.: _____

Patient Name: _____ Date: _____ Age: _____ Sex: _____

Address: _____

Phone (H): _____ (W): _____ SSN#: _____ DOB: _____

Insurance: _____

P.O. Box No.: _____ Group No.: _____ Account/ID No.: _____

Chief Complaint: _____

Provisional Diagnosis

(Please check Box)

- Obstructive Sleep Apnea
- Narcolepsy
- Restless Legs
- Periodic Limb Movements
- Nocturnal Seizures
- Abnormal Behaviors During Sleep
- Other _____

614.866.8200 or 866.751.5411

SLEEP LAB/CLINIC LOCATIONS

- Eastside Sleep Diagnostics Center Fax: 614.328.2812
- Knightsbridge Sleep Diagnostics Center Fax: 614.328.2812
- Grove City Sleep Diagnostics Center Fax: 614.328.2812
- Hilliard Sleep Diagnostics Center Fax: 614.328.2812
- Pickerington Sleep Diagnostics Center Fax: 614.328.2812
- Westerville Sleep Diagnostics Center Fax: 614.328.2812
- Newark Sleep Diagnostics Center Fax: 740.522.9448
- Lancaster Sleep Diagnostics Center Fax: 740.652.9931
- London Sleep Diagnostics Center Fax: 740.652.9931

*** PLEASE COMPLETE AND FAX WITH A COPY OF THE PATIENTS INSURANCE CARD ***

PLEASE CALL 614-866-8200 TO REQUEST ADDITIONAL REFERRAL PADS
AND USE THIS SHEET TO PHOTOCOPY UNTIL THEY ARRIVE. THANKS

