SLEEP CONSULT REFERRAL FORM

Medical Directors
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Last name	First name	MI
Phone	DOB	Gender

REASON FOR REFERRAL

___ Insomnia
___ Sleep Apnea / Snoring
___ Restless Leg Syndrome
___ Excessive daytime sleepiness
___ Parasomnias (sleepwalking, nightmares, sleep paralysis, etc.)
___ Other/Additional Requests:

PLEASE INCLUDE THE FOLLOWING:

- ☐ Demographic sheet & insurance info
- ☐ Recent clinical notes / last history & physical
- ☐ Any previous sleep or HST studies
- ☐ Medication list, including O_2

FAX TO PREFERRED LOCATION:

Location	Fax	Location	Fax
Rochester	f (585) 385.6071	N. Buffalo/Orchard Park	f (716) 662.1125
Batavia	f (585) 310.7447	Niagara Falls	f (716) 242.0611
Geneseo/Dansville	f (585) 335.4290	Olean/Springville	f (716) 379.8439

Practitioner's signature ______________________________ Date ____________

Practitioner's name (PRINT) ______________________________ NPI # ____________

Practice name ______________________________ **Dental Practice Y N**