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SUNSET SLEEP
& WELLNESS CENTER

PATIENT INFORMATION

Full Name: _____ Date: _____

Preferred Contact #: _____ Address: _____

_____

Insurance Provider: _____

Insurance ID #: _____ Patient DOB: _____

Previous Sleep Study: _____ YES _____ NO **FAX: Sleep study report, any prior sleep clinic notes.**

**It is important that we have prior sleep study report and/or sleep clinic notes at time of consult in order to provide timely care.

REASON FOR REFERRAL (MARK ALL THAT APPLY)

Sleep Dx:

_____ Obstructive Sleep Apnea
_____ Central Sleep Apnea
_____ Narcolepsy
_____ Idiopathic Hypersomnia
_____ Restless Leg Syndrome
_____ Parasomnia: (abnormal sleep behavior)
_____ Other: (Please list in comments)

Symptoms:

_____ Snoring
_____ Witnessed Apneas
_____ Daytime Somnolence
_____ Insomnia
_____ Nocturia
_____ Excessive Fatigue
_____ Weight gain
_____ Other: (list ir comments)

Associated Conditions:

_____ Atrial Fibrillation
_____ Other cardiac arrhythmia
_____ HTN
_____ CHF
_____ Obesity (BMI>35)
_____ Chronic pain
_____ COPD
_____ ADHD on stimulants

Is patient currently using PAP device: _____ YES _____ NO

Comments/Special concerns: _____

Requesting Physician's Name: _____

Office Phone: _____ Office Fax: _____

Office Contact: _____

Please call our office for any questions regarding insurance eligibility for your patients.