SUMMIT PACIFIC
• MEDICAL CENTER •

Sleep Clinic Referral Form

Phone: 360-495-5760 Fax: 360-495-5763

Patient Information

Height:_____ Weight:_____

Last name:_____ First name:_____ MI:_____ DOB:_____ Age:_____ Sex:_____

Address:_____ City/State:_____ Zip:_____

Home #:_____ Work #:_____ Cell #:_____ Email:_____

Referral Information

Provider:_____ Location:_____ Office Phone:_____

Contact Name:_____ Office Fax:_____

Diagnosis:_____ ICD 10:_____

Primary Insurance:_____ Coverage Eligibility Phone:_____

Member ID #:_____ Group #:_____ Effective Date:_____

Reason for referral:

- Sleep apnea symptoms
- Excessive daytime sleepiness
- Insomnia
- Sleep walking/talking
- Restless legs
- Nocturnal seizures
- Observed apnea
- Other: _____

Medical conditions:

- Diabetes
- Stroke
- Seizures/Epilepsy
- GERD
- Fibromyalgia
- CHF
- Hypertension
- Other: _____

What type of sleep testing (If applicable):

- Home sleep apnea test
- Diagnostic Polysomnography (no CPAP)
- Split-night Polysomnography
- Full night CPAP Titration
- Special Instructions/Other: _____

_____

Referral must be submitted with the following information:

- Patient face sheet
- List of current medications
- Surgical and medical history
- Recent history and physical
- Prior sleep studies, if available
- STOP-Bang score/Epworth sleepiness scale, if available