HEALTHYSLEEP AUSTIN

CREATING A PATH TO WELLNESS

Sleep Disorder Patient Referral Form

PATIENT'S NAME:_____**DATE:**_____

Phone number: _____**Date of birth:**_____**☐ Female ☐ Male**

Please evaluate patient for:

□ Oral appliance therapy

□ Combination oral appliance/CPAP

Diagnosis:

□ No sleep study yet

□ OSA code _____

□ Other

Appointment Scheduling:

□ You want us to call the patient for an appointment

□ Patient will call our office for an appointment

Referring Doctor's Name: _____**Phone:**_____

E-mail: _____

Please FAX this form along with the following documentation to 512-346-1372.

□ Copy of Diagnostic Night Polysomnograph (NPSG)

□ Letter of Medical Necessity from Physician

□ Prescription from Physician for Snore Guard

□ All relative clinical notes from Physician

Thank you