REFERRAL FORM

Integrative Insomnia & Sleep Health Center

PATIENT BACKGROUND INFORMATION	PATIENT CLINICAL BACKGROUND
_____ _____ **Pt Last Name** **Pt First Name** **Primary Dx:** _____ **DOB:** _____/_____/_____ **Sex** □ **M** □ **F** _____ **Address** _____ _____ _____ **City** **STATE** **ZIP** **Home Phone:** _____ **Cell or Work Phone:** _____ **SSN#:** _____ **Ins/Payer:** _____ **Group#:** _____	**If possible, please fax a copy of:** • **Relevant clinical notes pertaining to referral** • **Copy of the patient's insurance card and demographics** **We welcome any comments regarding referral or patient's history below:** _____ _____ _____ _____ _____ _____
	REASONS FOR ORDERING CONSULT
	Please Indicate Your Clinical Impressions: □ **Insomnia** □ **Obstructive Sleep Apnea/ Snoring** □ **Excessive Daytime Sleepiness** □ **Fatigue** □ **Strange Behaviors During Sleep** □ **Narcolepsy** □ **Other or Undetermined:** _____
REFERRING PHYSICIAN	
Physician: _____ **Address:** _____ **City:** _____ **Zip:** _____ **Tel:** _____ **Fax:** _____ **Specialty:** _____ **Contact:** _____ **Date of Order:** _____/_____/_____	
Thank you for your referral!	**INSURANCE AUTHORIZATION**
Please fax your referral to: **(858) 524-5937** **To discuss, please call: (858) 224-1866** **NPI #1245507599**	**We will help you obtain the insurance pre-authorization. Just fax a copy of:** • **Recent clinical notes prompting order** • **Copy of the patient's insurance card** • **Relevant data from patient's history**

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