Insomnia Consult Request

Fax order to: (763) 452-3956

Today's Date:

Patient Information					
Patient Name:			DOB:		Sex: M F
Address:		City:		State:	
Home Phone:			Cell :		
Primary Insurance (attach copy of card)					
Secondary Insurance					

Reason for Referral

◯ Cognitive Behavioral Therapy for Insomnia (CBT-I)

◯ CBT-I for patients dependent on sleep medications

Referral Clinic Information

Referring Clinic Name	**Referring Provider Name**
Clinic Contact Name: Phone: Fax:	◯ I want to be notified of Appt. Date/Time via: ◯ Fax ◯ Phone

NorthStar Sleep Center
3800 Coon Rapids Blvd. NW #3800
Coon Rapids, MN 55433
Phone: (763) 452-3955
Fax: (763) 452-3956

Appt. Date_______________and Time__________

◯ Patient Declined

◯ Unable to contact patient