NORTHSTAR SLEEP CENTER

3800 Coon Rapids Blvd. NW
Suite 3800
Coon Rapids, MN 55433
Phone: (763) 452-3955
Fax: (763) 452-3956

Fast Track

Fax to: **(763) 452-3956**

Date of Request: _____

Note: Medicare requires consult with Sleep Dr. before study.

Reason for Referral:

- ☐ Sleep Apnea
- ☐ Sleep Walking / Nightmares
- ☐ Sleepiness
- ☐ Nocturia
- ☐ Restless Leg
- ☐ Narcolepsy
- ☐ Obesity
- ☐ Snoring
- ☐ Witnessed Apnea
- ☐ Cardiac Disease
- ☐ Insomnia
- ☐ Other: _____

Patient Information

Patient Name: _____

Patient Address: _____

_____

Phone: _____ **Home/Work** **DOB:** _____

_____ **Cell** **Gender:** _____

Insurance Information

Primary: _____ **Secondary:** _____

Please attach copies of all insurance cards

Referring Clinic and Provider Information

Clinic Name: _____

Provider Name: _____

Contact Name: _____

Contact Phone: _____

Contact Fax: _____

☐ **I would like to be notified of appointment date/time**

Appointment Date: _____ ☐ Patient declined appointment

Appointment Time: _____ ☐ Unable to contact patient