Referral for Sleep Consultation

Fax referral to: **763-452-3956**

PATIENT INFORMATION		
Patient's Name (First, MI, Last):	Date of Birth (mm/dd/yyyy):	Gender:
Best time to contact patient:	Primary Phone:	Secondary Phone:
Special instructions:		
Insurance - please include copy of card(s):		

REASON FOR REFERRAL

Please check all that apply:

- ☐ Sleep apnea symptoms (e.g. snoring, gasping, choking, witnessed apnea)
- ☐ Excessive daytime sleepiness ☐ Insomnia ☐ Restless legs ☐ Sleep walking / talking
- ☐ Nocturnal seizures ☐ CHF ☐ Atrial fibrillation ☐ Inspire® hypoglossal nerve stimulator consultation
- ☐ Other: ____

REFERRING PROVIDER		
Date:	Your clinic name:	Provider (first, last, degree):
Clinic contact person:	Phone:	Fax:
Comments / Special instructions:		

Contact us:

Phone: 763-452-3955

Fax: 763-452-3956

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