

REFERRAL FOR SLEEP CONSULTATION

Please complete all sections of this form. In addition to this form, please fax insurance card, most recent history and physical and any previous sleep study reports.

Patient Information

Name _____ MRN# _____
Date of Referral _____ SS# _____ Date of Birth _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____
Referring Physician _____ Phone _____ Fax _____
Insurance Company _____ Authorization # _____
Primary Care Physician _____ Phone _____

Sleep Physician (please select)

- | | |
|---|---|
| <input type="checkbox"/> No Preference/First Available | <input type="checkbox"/> Dr. Jason Peck (South Charlotte) |
| <input type="checkbox"/> Dr. Eric Clemons (South Charlotte and Huntersville) | <input type="checkbox"/> Dr. Michael Reif (Charlotte and Arboretum) |
| <input type="checkbox"/> Dr. Urvi Desai (Charlotte and Matthews) | <input type="checkbox"/> Dr. Jaspal Singh (Charlotte and Arboretum) |
| <input type="checkbox"/> Dr. Michael Green (Charlotte and Arboretum) | <input type="checkbox"/> Dr. Thomas Stern (Charlotte, Huntersville-Adults and Pediatrics) |
| <input type="checkbox"/> Dr. Mark Letica (University and Pineville-Adults and Pediatrics) | <input type="checkbox"/> Dr. Ehrlich Tan (South Charlotte) |
| <input type="checkbox"/> Dr. Scott Lindblom (Charlotte and Arboretum) | <input type="checkbox"/> Dr. Michael Zgoda (University) |

Reason for Referral to Carolinas Sleep Services

- Snoring/Obstructive Sleep Apnea
 Daytime Sleepiness
 Restless Legs Syndrome
 Insomnia
 Other _____

How would you prefer to receive your sleep study results?

- Fax Fax # _____
 Mail Mailing Address _____
 Phone Call Phone # _____

Physician Signature _____



Carolinas Sleep Services

Uncompromising Excellence. Commitment to Care.

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www.carolinassleepservices.org