

Date: \_\_\_\_\_

## Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Physician Information

Referring Practice: \_\_\_\_\_

Ph: \_\_\_\_\_ Fax: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Dr. Signature: \_\_\_\_\_

## Diagnosis / Symptoms

(Please check all that apply.)

- Daytime sleepiness
- Frequent awakening
- Difficulty falling/staying asleep
- Previously diagnosed sleep apnea
- Wake up gasping
- Witnessed pause in breathing
- Snoring
- Other \_\_\_\_\_

Please select one of the following options:

## SLEEP SERVICES

**OUR** sleep physician will manage patient's care for their sleep health.

- Evaluate & Treat** (includes the following)
  - Initial appointment with our sleep physician
  - Follow up appointment to go over results and treatment options
  - Additional testing and/or CPAP setup if recommended
  - Ongoing management of care
- Comprehensive Sleep Service** (includes the following)
  - Split-Night Sleep Study (if insurance denies in lab study, proceed with Home Sleep Test)
  - Follow up to go over results and treatment options
  - Additional testing and/or CPAP setup if recommended
  - Ongoing management of care

## SLEEP STUDIES

**YOU** will manage patient's care for their sleep health.

- Split-Night Sleep Study w/CPAP Setup**  
\* If insurance denies in lab study, proceed with Home Sleep Test.
- Diagnostic Sleep Study**  
\* If insurance denies in lab study, proceed with Home Sleep Test.
- CPAP Titration Sleep Study w/CPAP Setup**
- BiPAP Titration Sleep Study w/BiPAP Setup**  
\* Must have documented failure of CPAP
- Home Sleep Test**
- Sleep Profiler (Insomnia Test)**
- Multiple Sleep Latency Test (includes Diagnostic Study)**

## CPAP & OTHER MEDICAL EQUIPMENT

- Auto-PAP** w/supplies  
Max Pressure \_\_\_\_\_ cmH20  
Min Pressure \_\_\_\_\_ cmH20
- CPAP** w/supplies  
Pressure \_\_\_\_\_ cmH20
- BiPAP S/ST** w/supplies  
Max Pressure \_\_\_\_\_ cmH20  
Min Pressure \_\_\_\_\_ cmH20  
PS \_\_\_\_\_ (If ST Needed)
- CPAP Mask & Supplies**



Sound sleep. Sound health.

## Referral Form

Fax this form to 919.462.8082 along with a copy of:

- Patient Demographics
- Medical History/Medications
- Insurance Card

We will verify insurance eligibility and contact and schedule the patient.

**CARY CENTER**  
 130 Preston Executive Drive  
 Cary, NC 27513

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