Home SLEEP HEALTH
SLEEP SOUNDLY, LIVE FULLY

37 West Center Street, 1A, Southington, CT 06489

SLEEP SERVICES REFERRAL FORM

Fax Completed Form To (844) 534-7652

* Diagnostic interpretation and clinical services are provided by Home Sleep Health Services, PLLC, a physician-owned medical practice.

1. PATIENT INFORMATION			
Last Name:	First Name:		M.I.
Street Address (No P.O. Box):	City:	State:	Zip:
Date of Birth (mm/dd/yyyy):	☐Male ☐Other ☐Female _____	Height:	Weight:
Primary Phone:	Secondary Phone:	Email:	

2. INSURANCE & PAYMENT INFORMATION	
Primary Medical Insurance:	ID#:
NOTE: Please include a copy of the patient's insurance card (front and back) in the fax	

3. SERVICES (Check as many services as needed)
☐ Home Sleep Test for Obstructive Sleep Apnea
☐ Telehealth Sleep Consultation with Board-Certified Sleep Physician
☐ Telehealth CPAP Therapy Management After Testing

4. FOLLOW-UP INSTRUCTIONS AFTER HOME SLEEP TEST IS COMPLETE
NOTE: If no follow-up instructions are selected, sleep report will be sent to ordering physician only
☐ A. Send sleep test report to **ordering physician only**
☐ B. Send sleep test report to both **ordering physician** and the following patient **preferred DME** for therapy: DME Name: _____ DME Fax#: _____
☐ C. Send sleep test report to **ordering physician** and have **Sleep Specialist** contact patient to manage therapy.

5. CLINICAL SYMPTOMS	
NOTE: Please check all that apply and include supporting chart notes in fax	**Epworth Sleepiness Scale Score: _____**
☐Snoring ☐Gasping During Sleep ☐Dry Mouth ☐Hypertension ☐Daytime Fatigue ☐Diabetes ☐Nocturia ☐Witnessed Apneas ☐GERD ☐Obesity ☐Unrefreshing Sleep ☐Other_____	

6. PRESCRIBER INFORMATION		
NOTE: Prescriber signature and date below required for referral		
Practitioner Name:	Address/City/State/Zip:	
NPI Number:	Referral Coordinator Name:	
Phone:	Fax:	
Prescriber Signature (required for referral):		**Date:**