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Sleep Education Clinic Referral Form

Please fill out this form completely and fax along with the last office notes and insurance card
If the patient is a minor (under 18 years of age) a parent or guardian must stay with them for the duration of the clinic visit

Name: _____ Gender: _____ DOB: _____

Home phone: _____ Work phone: _____ Cell phone:_____
(Please circle which phone number(s) we may use to contact patient)

PAP Therapy Issues:

_____ Patient Experiencing Mask Intolerance
_____ Patient Experiencing PAP Pressure Intolerance
_____ Patient Needs Mask Fitting
_____ Patient Needs Education For Using Mask
_____ Patient Needs Education For Using PAP Device and Equipment
_____ Patient Has Issues With Airway Dryness
_____ Patient Takes Off Mask/Mask Comes Off At Night While Sleeping
_____ Other (please specify): _____

Services Requested:

_____ ***Visit with Clinical Sleep Educator (CCSH) and permission for the Clinical Sleep Educator to adjust the mode and/or range of PAP therapy (CPAP versus APAP) using their clinical judgment during the Sleep Education Visit***

Signature: _____ Date: _____ Print Physician Name: _____

Physician Phone: _____ Physician Fax: _____