uNITE Sleep Center Referral Form

Phone: 775-433-0257
Fax: (775) 201-8376
Address: 2145 Green Vista Dr #112, Sparks, NV 89431

PATIENT INFORMATION

Last Name: _____ First Name: _____

DOB: _____ Gender: _____ Marital Status: _____

Street Address: _____ MI: _____ SSN: _____

Apt/PO: _____ City: _____ Home Phone: _____ Work Phone: _____

State: _____ Zip: _____ Cell Phone: _____ Fax: _____

PRIMARY INSURANCE

Company: _____ ID#: _____ Group: _____

Address: _____ Phone: _____

Subscriber: _____ Guarantor: _____

DOB: _____ Employer: _____

THIS PATIENT IS BEING REFERRED FOR: *(Please check all that apply)*

- ☐ Diagnostic Sleep Study (In Lab or HST if required by insurance)
- ☐ Split night sleep study
- ☐ Titration sleep study ☐ CPAP ☐ BiPAP ☐ ASV ☐ IVAPS/ AVAPS
- ☐ Multiple Sleep Latency Test
- ☐ Maintenance of Wakefulness Test
- ☐ Overnight Pulse Oximetry

SPECIAL INSTRUCTIONS:

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SUSPECTED DISORDERS AND RELEVANT MEDICAL HISTORY: *(Check all that apply and include clinic notes)*

- ☐ Obstructive Sleep Apnea
- ☐ Insomnia
- ☐ Narcolepsy
- ☐ Periodic Limb Movements (PLMs)
- ☐ Parasomnias/Nocturnal Seizures
- ☐ Central Sleep Apnea
- ☐ Cardiac Conditions
- ☐ Neurologic Disorder
- ☐ COPD
- ☐ Morning Headache
- ☐ Daytime Fatigue
- ☐ Snoring Prior Sleep Study
- ☐ In lab PSG Date: _____
- ☐ HST Date: _____

REFERRING PROVIDERS INFORMATION

Provider Name: _____ Phone: _____ Fax: _____

Address: _____ NPI#: _____

_____ _____

Signature Date

Please include Patient Demographics, insurance card, and clinical notes documenting any comorbidities and the medical necessity of the sleep study.