National Sleep Solutions Inc.
Sleep specialist

Fast Track
for Sleep Study
Fax to: 888-884-9493

PATIENT INFORMATION

Date of Request:_____ Birth Date:_____

Patient Name:_____ Sex:_____

Address:_____

Cell/Other_____

Insurance Carrier: (Attach copy of card)

Primary:_____

Secondary:_____

___Apt Date_____ Time____
___Pt declined apt
___Unable to contact patient

REASON FOR REFERRAL: ___SLEEP STUDY EVAL AND TREAT
_____EEG EVAL AND TREAT

___Sleep Apnea	___Restless Leg	___Snoring
___Sleep Walking/Nightmares	___Narcolepsy	___Cardiac Disease
___Sleepiness	___Obesity	___Other:
___Nocturia	___ Witnessed Apnea	

Sleep Tests

___ Diagnostic Sleep Test	___ CPAP Titration	___ MSLT
___ Home Sleep Test	___ MWT	

EEG Tests

____Routine EEG 41/60 mins	____ Routine Over 1hr	____ EEG All night
____ EEG Monitoring Video	____ EEG Monitor Tech Attended	____ EEG other

____ Please notify me with apt date/time

_____ _____
Referring Physician Signature Date

_____ _____
Physician NPI Contact Number