

Patient Information

Name	DOB
Email	Phone
Mailing Address	Zip Code

Reason For Referral *(select all that apply)*

- Suspected Sleep Apnea Evaluation / Management
- PAP Therapy Initiation / Management (APAP, BiPAP, BiPAP ST, ASV)
- PAP Intolerance / Nonadherence
- PAP Failure Despite Optimization
- Treatment Emergent Central Sleep Apnea (TECSA)
- Sleep Study Interpretation / Second Opinion
- Inspire Hypoglossal Nerve Stimulator Evaluation / Management
- remedē Phrenic Nerve Stimulator Evaluation / Management
- Evaluation for Alternative Therapy Options for Snoring / Sleep Apnea
- Other *(please describe in Clinical Notes)*

Symptoms *(select all that apply)*

- Snoring
- Witnessed Apneas
- Excessive Daytime Sleepiness
- Morning Headaches
- Unrefreshing Sleep / Fatigue /
- Frequent Awakenings
- Insomnia
- Mood Changes / Cognitive Concerns
- Other *(please describe in Clinical Notes)*

Relevant History

Prior Sleep Study	None	Home Sleep Study	Laboratory PSG / Split Night / Titration
Date of Study	AHI	CAHI	
PAP Compliance	Compliant	Non-Compliant	Intolerant N/A

Preferred Office Location

Coeur d'Alene
 1717 Lincoln Way STE 201
 Coeur d'Alene ID 83814
 Airway Institute

Spokane Valley
 12410 E Sinto Ave STE D
 Spokane Valley WA 99216
 Aspen Sleep Centers

No preference

Relevant Comorbidities

- Heart Failure *(please note LVEF in Clinical Notes)*
- Atrial Fibrillation
- Coronary Artery Disease
- Hypertension
- Stroke / TIA History
- Opioid Use
- Other *(please describe in Clinical Notes)*

Prior/Current Therapies

- CPAP
- BiPAP
- ASV or BiPAP ST
- Oral Appliance
- Hypoglossal Nerve Stimulation (HGNS)
- Transvenous Phrenic Nerve Stimulation (TPNS)
- Positional Therapy
- Surgical Intervention *(please specify in Clinical Notes)*
- None / Treatment-Naive

Clinical Notes

Items to Include

Please include the following items when submitting the referral form.

- Patient face sheet / demographics page
- Copy of the patient's insurance card(s) front and back
- Insurance authorization (if required)
- Copy of valid photo ID
- Relevant medical records, sleep studies, PAP download, echocardiogram, medication list, recent clinic notes

Referring Provider

Name	Phone
Email	Fax
Referring Provider Signature	Date