

Patient Information

Name _____ DOB _____

Email _____ Phone _____

Mailing Address _____ Zip Code _____

Reason For Referral *(select all that apply)*

Pediatric Sleep Disordered Breathing Evaluation/Management

Other _____

Other _____

Other _____

Other _____

Other _____

Symptoms *(select all that apply)*

Snoring

Witnessed Apneas / Pauses in Breathing

Mouth Breathing

Restless Sleep

Nocturnal Enuresis

Hyperactivity / Behavioral Difficulties

Attention / Concentration Difficulties

Feeding Difficulties *(Infants)*

Failure to Thrive

Other _____

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

DME Information

Company _____ Phone _____

Relevant History

Prior Sleep Study None Home Sleep Study Laboratory PSG

Result: AHI _____

Current PAP Therapy None CPAP APAP BiPAP BiPAP ST ASV

PAP Compliance Compliant Non-Compliant Intolerant N/A

Relevant Comorbidities _____

Current Medications _____

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, like patient history, clinical notes, labs, imaging reports

Referring Provider

Name _____ Phone _____

Practice _____ Fax _____

Email _____

Comments

Referring Signature _____ Date _____