VALLEY SLEEP & WELLNESS CENTER

Referral Form

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1660 East Herndon Ave , Suite #102, Fresno, CA 93720
(559) 840-2262
Fax (559) 840-2855

ACCREDITED MEMBER CENTER

Patient Information*

Name: Today's Date:

Address: DOB:

Phone: Gender:

Insurance & Policy #: Height/Weight:

Patient Symptoms	Comorbidities	Diagnostics/Tests
☐ Witnessed/Suspected Sleep Apnea	☐ Diabetes	☐ Sleep specialist consult
☐ History of sleep apnea	☐ BMI:____	☐ Baseline polysomnogram
☐ Snoring	☐ Mood/Anxiety disorder	☐ CPAP/BIPAP titration
☐ Daytime Sleepiness	☐ Epworth Sleepiness Scale (ESS) score of 10+	☐ Home sleep test
☐ Morning Headaches	☐ Neuro: Seizure Dx, Neuromuscular Disease , Parkinson, Other:_____	☐ Inspire Sleep System
☐ Insomnia		☐ Evaluation of OSA after surgery
☐ Movement disorders		☐ Evaluation of OSA before D/C of PAP usage
☐ Narcolepsy	☐ Resp: COPD, PHTN, Respiratory Failure, Other:_____	☐ PAP/mask reassessment
☐ Frequent awakenings/ urinations		☐ Pediatric sleep study
☐ Other:_____	☐ Cardiac: CHF, CAD, HTN, AFib, Other:_____	☐ Overnight Pulse Oximetry
		☐ Other:_____

Referring Physician

Ordering Physician: Office Contact:

Physician Signature: Office Phone:

NPI: Office Fax/email:

*Please include patient's last visit notes, insurance card, demographics and HMO authorization.
Fax to 559-840-2855