Sleep Medicine Institute
OF TEXAS, PA

FAX FOR REFERRALS ONLY: 903-630-7141

PATIENT REFERRAL FORM

Patient Name:_______________________________________DOB: _____________________

Gender:______________Height: ________________Weight: _______________lbs

Home Phone: ______________________________Cell Phone: __________________________

Allergies: ____

Referring Physician: ______________________________Signature: ______________________

Name of Contact Person at Referring Physician's office: ________________________________

Phone of contact person: _______________________________fax: ______________________

Choose the appropriate referral order from the following:

1. Consultation with Dr. Ghuge for Sleep Disorder.

2. Consultation with Dr. Ghuge and sleep study.

Medical Necessity for referral: (Check all that apply)

__ ADD/ADHD	__ Daytime Sleepiness	__ Insomnia	__ Restless leg syndrome
__ Bedwetting	__ Depression	__ Memory Loss	__ Seizures
__ Bruxism	__ Fatigue	__ Narcolepsy	__ Sleep Apnea
__ Cardiac Arrhythmias	__ Headaches	__ Nocturnal acid reflux	__ Sleep walking
__ CHF	__ Hypertension	__ Obesity	__ Snoring
__ Coronary art. Disease	__ Impaired Cognition	__ Periodic limb movements	__ Stroke

PLEASE FAX THIS FORM ALONG WITH THE FOLLOWING DOCUMENTS:

1. **Referral number and Number of authorized visits**
2. **Primary and Secondary Health Insurance cards copies (front and Back)**
3. **Patient demographic information**
4. **Clinical notes, Echocardiogram and previous sleep study reports**