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THANK YOU FOR YOUR REFERRAL!

PATIENT NAME: ____

DOB: _________________________________ **GENDER:** ________________________

Patient Email: ____

PH: HOME: ___________________ **WORK:** _________________ **CELL:** ____________________

Provider Name: ______________________________________**Signature:** ______________________

Provider's contact person: _____________________________________

Ph. ____________________________ **FAX:** _________________________

1. **Consultation and management of sleep disorders at Sleep Medicine Institute of Texas**
2. **Sleep testing at Sleep Medicine Institute of Texas**
3. **CPAP/BIPAP device and/or CPAP supplies**
4. **Custom Mandibular Repositioning Device (AIO BREATHE) for snoring/OSA**

Does the patient have any of the following symptoms or diagnosis? (Optional)

☐Snoring ☐Sleep apnea ☐Excessive Daytime Sleepiness ☐Fatigue ☐Insomnia
☐Impaired Cognition ☐Headaches ☐Depression & mood swings ☐Pulmonary hypertension
☐Hypertension ☐Stroke ☐CHF ☐Cardiac Arrhythmia ☐Coronary artery disease
☐Obesity ☐Narcolepsy ☐Periodic limb movements of sleep ☐Restless leg syndrome
☐Memory loss ☐Abnormal sleep behavior ☐Bedwetting ☐Seizures ☐Adeno-Tonsillar hypertrophy with snoring ☐ADD/ADHD ☐Sleep-walking ☐Bruxism ☐Nocturnal acid reflux
Other Diagnosis: ____

PLEASE FAX THIS FORM WITH THE FOLLOWING INFORMATION:

1. Copy (front & back) of insurance card
2. Patient demographic information
3. Clinical notes and test