**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Stanford Referral Center**

**Phone: (877) 254-3762**

**# of pages faxed**\_\_\_\_\_\_\_ **Fax**: **(650) 320-9443**

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| **Referring Provider Information:**  Referred by (MD): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Group:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_  This form completed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ |
| **Patient Information *(Please provide copy of patient demographics/face sheet)*:**  Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI \_\_\_\_\_\_  DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male/Female Phone: \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Ht\_\_\_\_ Wt\_\_\_\_  Patient’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Needs Interpreter? Y / N Language:\_\_\_\_\_\_\_\_\_\_\_\_\_  Needs Assistance:  assistive devices ADLSs wheelchair  seizure precautions |

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| **Reason for Referral:**  Diagnosis/ICD-9 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician (if Requested):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  OR | |
| Type of Consult:   * Clinic Consultation (MD) *(may include PSG as indicated)* * Behavioral Sleep Medicine/ Insomnia Therapy | Type of Sleep Lab Test Requested:   Lab Test only - without consult **(clinic notes reqd)**   Diagnostic   CPAP\*   Bilevel\*  \***Indicate Starting** **Pressure(s)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   EtCO2  TcCO2  extra limb EMG leads  Pes |
| Note: Clinical evaluation first is required for Multiple Sleep Latency Test, Maintenance of Wakefulness Test, and seizure montage ; it is strongly recommended for advanced Bilevel modalities (e.g. Auto SV, Adapt SV, AVAPS, ST and PC modes, etc)  Additional Info/ Instructions (I**ndicate further clinical information and/or titration instructions here)**:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **Documentation Required *(please fax with this form):***   * **Recent/relevant typed clinical notes/test results**, i.e. History & Physical, MRI/CT/X-rays results * Proof of Insurance * Authorization information (if required) |