**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)
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