STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center

# SLEEP REFERRAL REQUEST FORM

***Thank you for choosing Stanford Hospital and Clinics. We look forward to partnering with you in your patient's care.***

**Date**_____

**# of pages faxed**_____

**Stanford Referral Center**
**Phone: (877) 254-3762**
**Fax: (650) 320-9443**

## 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

## 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)**:

_____

_____

## 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)