Referral for Sleep Disorder Consult and Study

Fax completed form to **(480) 991-0478**
Please include a copy of the patient's history, physical, and insurance card.

Reason for Referral (check all that apply)

- ❑ Loud Snoring (786.09)
- ❑ Insomnia (307.42)
- ❑ Daytime Fatigue (780.79)
- ❑ Witnessed Sleep Apnea (780.53)
- ❑ Non Restoring Sleep
- ❑ Restless Legs (780.10)
- ❑ Diagnosed Sleepiness
- ❑ Daytime Sleepiness
- ❑ Shift Work Related
- ❑ Other (please specify) ____

Procedure Ordered

Consult Diagnostic PSG PSG Titration Split PSG MSLT MWT

Patient's Name____

Date of Birth ___________________________________ Phone__________________

Primary Insurance ________________________________ ID # ___________________

Secondary Insurance______________________________ ID # ___________________

Referring Dr._____________________________________ Phone__________________

Signature ____ UPIN__________________

Any questions please call REM Medical @ (480) 991-0480

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Mesa: 7205 East Southern Avenue Suite 111 Phone: (480) 981-0438 Fax: (480) 981-0439

Scottsdale: 10615 North Hayden Road Suite 100 Phone: (480) 991-0480 Fax: (480) 991-0478