



5777 West Maple Road, Suite 185
 West Bloomfield, MI 48322
HealthySleepMD.com

Phone: (248) 688-0088
 Fax: (248) 757-0005
 e-mail: info@healthysleepmd.com

PATIENT REFERRAL FORM

Last Name: _____ First Name: _____ M.I.: _____

Date of birth: _____ Contact number: _____

Street address: _____ City: _____ State: ____ Zip: _____

Referring Clinician: _____

Office phone: _____ Office fax: _____

Office address: _____ City: _____ State: ____ Zip: _____

Reason for referral

- | | |
|---|---|
| <input type="checkbox"/> Snoring (R06.83) | <input type="checkbox"/> Inspire/ surgical alternatives |
| <input type="checkbox"/> Obstructive sleep apnea (G47.33) | <input type="checkbox"/> Oral appliance candidacy |
| <input type="checkbox"/> Central sleep apnea (G47.30) | <input type="checkbox"/> Nocturia |
| <input type="checkbox"/> CPAP intolerance (Z78.9) | <input type="checkbox"/> Arrhythmia |
| <input type="checkbox"/> Hypersomnia (G47.10) | <input type="checkbox"/> Congestive heart failure |
| <input type="checkbox"/> Insomnia (G47.0) | <input type="checkbox"/> Presurgical sleep evaluation |
| <input type="checkbox"/> Restless leg syndrome (G25.81) | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Parasomnia (G47.5) | <input type="checkbox"/> Department of Transportation visit |
| <input type="checkbox"/> Circadian rhythm disorder (G47.20) | <input type="checkbox"/> Other: _____ |

Additional comments:

Please email or fax this completed form in addition to relevant office notes, any previous sleep studies, machine downloads if applicable, driver's license and insurance card(s). Please advise the patient to call our office if they do not receive any correspondence within 2 business days.