WATERSTONE
Sleep & Neuroscience Associates

Sleep Services Referral Form

Fax Completed Form to 203.427.0441

1. PATIENT INFORMATION			
Last Name:	First Name:		M.I.
Street Address (No P.O. Box):	City:	State:	Zip:
Date of Birth (mm/dd/yyyy):	☐Male ☐Other ☐Female _____	Height:	Weight:
Primary Phone:	Secondary Phone:	Email:	

2. INSURANCE & PAYMENT INFORMATION	
☐Check Box for Self-Payment Option ($290 on Credit-Card)	
Primary Medical Insurance:	ID#:
NOTE: If possible, please include a copy of the patient's insurance card (front and back) in the fax	

3. SERVICES (Check as many services

☐Home Sleep Test for Obstructie Sleep Apnea ☐Home Sleep Test for GLP-1 Qualification

☐Comprehensive Sleep Consultation ☐CPAP Therapy Management

4. FOLLOW-UP INSTRUCTIONS

NOTE: If Home Sleep Test is selected, please select follow-up instructions below.

☐A. Send sleep test report to **ordering physician only**

☐B. Send sleep test report to both **ordering physician** and the following **preferred DME** provider for therapy:
DME Name: _____ DME Fax#: _____

☐C. Send sleep test report to **ordering physician** and have **Sleep Specialist** contact patient to manage therapy.

5. CLINICAL SYMPTOMS

NOTE: Please check all that apply and include any supporting chart notes in fax

☐Snoring ☐Gasping During Sleep ☐Dry Mouth ☐Hypertension ☐Daytime Fatigue ☐Diabetes
☐Nocturia ☐Witnessed Apneas ☐GERD ☐Obesity ☐Unrefreshing Sleep ☐Other_____

6. PRESCRIBER INFORMATION

NOTE: Prescriber signature and date required for referral

Practitioner Name:	Address/City/State/Zip:
NPI Number:	Referral Coordinator Name & Email:
Phone:	Fax:

Prescriber Signature (Required): **Date:**

_____ _____

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