Ashwin Gowda, MD
Board Certified in Sleep Medicine

TEXAS SLEEP MEDICINE

REFERRAL FORM

Patient Information (please print)

Name _____ Phone # _____

Referral for Evaluation

❑ Consultation and Management

Consultation followed by a treatment plan and ongoing care.

** OR **

❑ Home Sleep Testing

Texas Sleep Medicine will contact patient to initiate home delivery of testing equipment (please check either option below)

**Fax the following with this referral form:

1. patient demographics
2. insurance card copy
3. supporting clinical note

❑ Texas Sleep Medicine to review results with patient via office visit or telemedicine visit and manage care

** OR **

❑ Referring provider to review results with patient and manage care

Referring Office _____ Contact Phone # _____

PLEASE FAX to (512) 440-5858

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1221 W. Ben White Blvd. Suite A-100 Austin, TX 78704
Tel (512) 440-5757 • Fax (512) 440-5858