DENALI HEALTHCARE SPECIALISTS

REFERRAL FORM
PULMONOLOGY / SLEEP MEDICINE

PATIENT PROFILE			
Last Name:	First name:	Date of Birth:	Age: □ Male □ Female
Address:			
Telephone #:	Alt. Phone #:	Email Address:	
Primary Insurance:		Secondary Insurance:	

REASON FOR PATIENT REFERRAL

SERVICES REQUESTED			
	Pulmonary Consultation		
	Full Pulmonary Function Tests (Pre- and post-bronchodilator spirometry, lung volumes, and diffusion test)		
	Pre- and Post-Bronchodilator Spirometry		Spirometry without Bronchodilator
	Diffusion Test (DLCO)		Lung Volumes
	6-Minute Walk Study		Methacholine Challenge Test
	Sleep-Related Disorder Consultation		

Suspicious Symptoms

☐ Observed Apneas ☐ Choking / Gasping (asleep)
☐ Loud Snoring ☐ Excessive Sleepiness
☐ Chronic Fatigue ☐ Drowsy Driving
☐ Morning Headaches ☐ Frequent Awakenings
☐ Leg Restlessness / Jerks ☐ Sleepwalking / Talking
☐ Nocturnal Behaviors ☐ Cataplexy / hallucinations
☐ Other:_____

Suspected Diagnosis

☐ Sleep Apnea ☐ Parasomnias
☐ Narcolepsy ☐ Insomnia
☐ Restless Legs Syndrome
☐ Sleep-related Movement Disorder
☐ Circadian Rhythm Sleep Disorder
☐ Other:
_____

Referring Physician: _____ NPI: _____
Address: _____ Phone:_____ Fax:_____
Special Instructions: _____
Signature: _____ Date: _____

Please fax referral form to us along with patient demographics, insurance card(s), and relevant clinical notes.
Thank you for referring your patient to us!

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