PATIENT REFERRAL FORM

Patient's Name: ______________________________ Date of Birth: ________________ Male Female

Address: ____ Phone: _________________

□ **Initial Consultation:** Comprehensive evaluation of patient for consideration of diagnostic sleep study. Suspicious symptoms suggestive of obstructive sleep apnea include:

- Observed apneas
- Loud snoring
- Excessive daytime sleepiness
- Chronic fatigue
- Drowsy driving
- □ Falling asleep at inappropriate times
- Dry mouth upon awakening
- Frequent awakenings
- Choking/gasping while asleep
- Morning headaches
- Prior diagnosis of OSA
- Other _________________

Re-Evaluation Consultation*:* Evaluation of patient for titration polysomnography with oral appliance.
Titration instructions:
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Kindly keep me informed of the polysomnography results and my patient's progress.

Referring Dentist : __________________________________

Dentist's Signature: _________________________________

Date: ___________________ NPI: ________________

Address: ____

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Phone: __________________ Fax: ________________

Special Instructions:

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Please fax referral form, patient demographics, insurance card, and pertinent clinical notes.

PREFERRED LOCATION

□ **Anchorage** *(907) 677-8889*
2421 East Tudor Road, Suite 102
Anchorage, AK 99507
Fax: (907) 677-8886

Wasilla *(907) 357-8410*
351 West Parks Highway, Suite 100
Wasilla, AK 99654
Fax: (907) 357-8423

Soldotna *(907) 260-9520*
35670 Kenai Spur Highway, Suite 103A
Soldotna, AK 99669
Fax: (907) 260-9510

Fairbanks *(907) 328-0582*
3202 International Street, Suite 200
Fairbanks, AK 99701
Fax: (907) 328-0586

THANK YOU FOR REFERRING YOUR PATIENT TO US!