Referral Request

Thank you for choosing Golden Gate Sleep Centers.

We look forward to partnering with you in your patient's care.

☐ **Routine**

☐ **Urgent**

Date: ________________

Golden Gate Sleep Centers

Phone: 925-820-GGSC (4472)
Fax: 925-820-2650

Clinic and Lab Centers:
39055 Hastings St, Suite 106
Fremont, CA 94538

400 El Cerro Blvd, Suite 107
Danville, CA 94526

REFERRING PROVIDER INFORMATION:

Referred by (MD / Provider): ________________________________

Medical Group: ________________________________

Phone: ______________________ Fax: ______________________

PCP: ________________________________

Address: ______________________________ City: ______________

ZIP: ______________ Phone: ____________________

This form completed by: ____________________________

PATIENT INFORMATION (Please provide copy of patient demographics/face sheet):

Last Name: ______________ First Name: ______________ MI: ________

DOB: ______________ Cell: ______________ Home: ______________

Patient's Address: ________________________________

City/State/Zip: ______________________________ Gender: __ Male __ Female

REASON FOR REFERRAL:

Diagnosis/ICD: Obstructive Sleep Apnea, AFIB, Insomnia, Narcolepsy, RLS, Snoring, or

Other: ________________________________

DOCUMENTATION REQUIRED (Please fax with this form):

- Recent/relevant typed clinical notes/test results, i.e. history & physical, PSG Results
- Proof of insurance
- WE WILL GET THE PRE-AUTHORIZATIONS

Please give patient our business card. In an unlikely event, if the patient does not hear from us within 48 hours they should call us at: 925-820-GGSC (4472).