Golden Gate Sleep Centers

Referral Request

Thank you for choosing Golden Gate Sleep Centers.

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

Date: _____

☐ **Routine**

☐ **Urgent**

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

2222 Camino Ramon
San Ramon, CA 94583

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).