Ed Charnock, MD, FAASM
Jack Gardner, MD, FCCP

Accredited by the American Academy of Sleep Medicine

PATIENT CONSULTATION & TREATMENT REFERRAL

PATIENT NAME: _____ **DATE:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL PHONE:** _____

INSURANCE INFORMATION

Please attach patient demographics and insurance information.

CLINICAL INFORMATION

_____Snoring
_____Witnessed Stopped Breathing Or Choking
_____BMI Greater Or Equal To 35
_____Excessive Daytime Sleepiness
_____Sleep Paralysis
_____Sleep Walking Or Night Terrors
_____Insomnia
_____Restless Legs Syndrome
_____Periodic Limb Movements Of Sleep
_____Shift-Work Sleep Disorder
_____Cataplexy
_____Other Sleep Disorders (Describe)
_____
_____

_____ **Pre-surgical Sleep Evaluation**

Sleep Medicine Consultation & Treatment is requested.

_____ **Referring Physician's Signature**

_____ **Date**

_____ **Referring Physician's Name (Printed)**

_____ **Referring Physician's NPI**

_____ **Office Phone Number**

_____ **Office Facsimile Number**

PLEASE SEND VIA FACSIMILE TO 972-780-4796.