

REFERRAL FORM FROM CLINIC



REFERRAL DATE: _____

FROM FACILITY: _____ PHONE#: _____ FAX #: _____

REFERRING PHYSICIAN: _____ SPECIALTY: _____ NPI #: _____

PATIENT INFORMATION:

PATIENT NAME: _____

ADDRESS: _____

EMAIL: _____ EMPLOYER: _____

BEST DAYTIME #: _____ BEST EVENING #: _____

___ MALE ___ FEMALE DOB: _____ MARITALSTATUS ___ S ___ M ___ D ___ W

MEDICAL INSURANCE INFORMATION:

SUBSCRIBER INFORMATION: _____ DOB: _____ SS#: _____

INSURED COMPANY NAME: _____ INS CO PHONE#: _____

SUBSCRIBER ID: _____ GROUP #: _____

SYMPTOMS

___ FATIGUE/DAYTIME SLEEPINESS	___ JAW PAIN	___ RINGING IN EARS/EAR PAIN
___ WITNESSED APNEA	___ HEADACHES	___ WEARS CPAP/INTOLERANT
___ CHOKING/GASPING FOR AIR	___ NECKACHES	___ LOSS OF ENERGY
___ OBESITY	___ BRUXISM	___ ASTHMA
___ SNORING	___ DEPRESSION	___ RESTRICTED AIRWAY
___ OTHER: _____		

ORDER/REQUEST:

___ EVALUATION FOR TMD/TMJ WITH CLINICAL EXAMINATION
___ PATIENT HAS BEEN DIAGNOSED WITH TMD/TMJ, BUT CURRENT APPLIANCE/THERAPY IS INEFFECTIVE
___ EVALUATION FOR POSSIBLE SLEEP BREATHING DISORDERS AND SLEEP STUDY REFERRAL
___ PATIENT HAS CPAP/BIPAP, BUT IS INTOLERANT**
___ PATIENT HAS BEEN DIAGNOSED WITH OBSTRUCTIVE SLEEP APNEA OR SIMPLE SNORING BUT NEVER TREATED**

****INCLUDE PATIENT MOST RECENT SLEEP STUDY & PRESCRIPTION FOR MANDIBULAR ADVANCEMENT DEVICE THERAPY**

PHYSICIAN SIGNATURE: _____