Sleep Centers of Texas

PATIENT REFERRAL FORM

Patient's Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____ Phone: _____

☐ **Initial Consultation:** 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:

_____

_____

Kindly keep me informed of the polysomnography results and my patient's progress.

Referring Dentist : _____ NPI:_____

Dentist's Signature: _____ Date: _____

Address: _____ Phone: _____ Fax: _____

Special Instructions:

_____

_____

Please fax referral form, patient demographics, insurance card, and pertinent clinical notes to selected clinic location.

☐ **San Antonio Office**

7839 Interstate 10 West, San Antonio, TX 78230

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