

**Koala Center for Sleep Disorders
Referral Form**

Today's Date _____

Please fax pertinent Medical Records with this form to our office fax number. Thank you!

Reason for Referral: Sleep Apnea TMD - Temporomandibular Joint Disorder

Referring MD name _____ MD NPI # _____

Your name _____ Phone number of office _____

Patient Information:

Last Name _____ First Name _____ Middle Initial _____

Address _____ Zip Code _____ Sex: Male / Female

Date of Birth: _____

Home Phone _____ ()

Work Phone _____ ()

Cell Phone _____ ()

E-mail Address: _____

Clinical Information:

This patient has been diagnosed with Sleep Apnea? Y / N

Location of Sleep Study? _____

Date of Baseline Sleep Study _____

Is this patient PAP Intolerant? Y / N

Please fax copy of baseline sleep study if possible.

Responsible Party (if other than patient):

Last Name _____ First Name _____ Middle Initial _____

Address _____ Zip Code _____ Sex: Male / Female

Employer: _____ Title: _____ DOB: _____

Medical Insurance Information (please advise patient to bring cards to their appt)

Primary Insurance Carrier: _____ Group #: _____

Subscriber Name: _____ Member ID: _____

Group Name (Employer) _____ Ins Company Phone #: _____

Relationship of Subscriber to patient: _____ Subscriber Birthdate: _____

Secondary Insurance Carrier: _____ Group #: _____

Subscriber Name: _____ Member ID: _____

Group Name (Employer) _____ Ins Company Phone #: _____

Relationship of Subscriber to patient: _____ Subscriber Birthdate: _____