Koala Center for Sleep Disorders
Referral Form

Today's Date _____

Please fax pertinent Medical Records with this form to *(309)265-0274*. **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: _____