



Patient Referral Form

Please fax this form with pertinent information to **Fax #888-837-0875**

Patient Name: _____ DOB: _____

Responsible Party: _____

Best Phone: _____ Alt. Phone: _____

Patient Email: _____

Medical Insurance Carrier(s): _____

Reason for Referral:

_____ Sleep Apnea _____ TMJ Disorder _____ Other

If Sleep Apnea Referral, please also Fax Chart Notes Related to Sleep Apnea including:

- Baseline Sleep Study with Diagnosis and Interpretation
- Face to Face Encounter Notes *Before and After* Sleep Study Order
- If PAP intolerant, Therapy Attempts and Reasons for Intolerance
- A Detailed Written Order/Rx for Mandibular Repositioning Device (DME item)

Comments: _____

Referring Doctor:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

NPI Number: _____

Thank you for your referral. Our office will contact your patient for a consultation and keep you informed of their treatment progress.

Brian Sorensen, DDS, Jackie Rietz, APNP, FNP-C

413 N. 17th Ave, Ste 100, Wausau, WI 54401

P: **715-298-4454** F: **888-837-0875**

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