

UNITED SLEEP MEDICINE REFERRAL FOR CONSULTATION

**CALL Order Request # 910-484-7744
FAX Order Request # 910-484-7741**

(Please print legibly in ink and fill out form completely)

Date _____ Referring MD _____ Location _____

Practice Name _____ Practice Contact Person _____

Contact Phone # _____ Ext # _____ Fax # _____

Your E-mail address _____

Patient Name _____ Male / Female

Patient's DOB _____ Patient's SS # _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

Patient E-mail address: _____

If patient is a minor, this section must be completed.

Responsible Party _____ DOB _____

SS # _____ Relation to patient _____

Patient's Special Needs/Comments _____

Chief Complaint(s) please check all that apply: Apnea Snoring Hypersomnia

Insomnia Restless or Periodic Limb Movement Parasomnia Narcolepsy

Other: _____

Insurance Carrier _____ Policy # _____

Group Name _____

Referral or Authorization # (if applicable) _____

**FAX LEGIBLE COPY OF INSURANCE CARD (FRONT & BACK)
TO: # 910-484-7741**

UNITED SLEEP MEDICINE will fax back the information in this section*

*Appointment Scheduled on _____ at _____ am / pm
with Dr. Ryan Conrad, MD/ United Sleep Medicine/ 2919 Breezewood Ave., Ste 300/ Fayetteville

If you experience a problem in getting this referral through to United Sleep Medicine, please contact our Clinic Manager, at # 910-484-7744

06/09

United Sleep Medicine/ 2919 Breezewood Ave., Ste 300/ Fayetteville