

# UNITED SLEEP MEDICINE REFERRAL FOR CONSULTATION

**CALL Referral # 704-377-5337 option 2**  
**FAX Referral # 704-973-9346** (alternate Fax # 704-377-9992)

(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: # 704-973-9346** (fax #) (alternate Fax # 704-377-9992)

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

\*Appointment Scheduled on \_\_\_\_\_ at \_\_\_\_\_ am / pm  
with Dr. \_\_\_\_\_ Office Location: \_\_\_\_\_

*Appointment notification will be faxed back for your records. We make every effort to contact the patient regarding setting up the appointment. IF WE DO NOT reach the patient after 3 attempts, we will ask the referring office to please contact them regarding setting up their appointment. As always, "Thank You" for your referrals!*

If you experience a problem in getting this referral through to United Sleep Medicine, please contact our Manager, Monica Case at # 704-953-5356