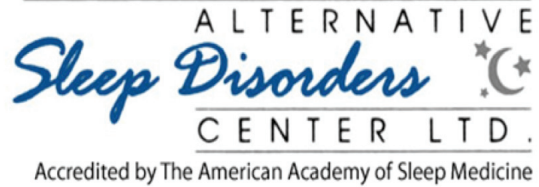


Referral/Order Form



Patient Info:

Name: _____

Date: _____

DOB: _____ Referring Physician: _____

Home Phone #: _____ ALT Phone#: _____

SYMPTOMS

- | | | |
|--|---|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Choking/Gasping | <input type="checkbox"/> Fatigued | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Restless Sleep | <input type="checkbox"/> Morning Headache |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Neck Size > 16 in | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Gastro Esophageal Reflux | <input type="checkbox"/> Frequent Urination at night |
| <input type="checkbox"/> History of Stroke | <input type="checkbox"/> Ischemic Heart Disease | |

SERVICE REQUESTED

- Consult with Dr. Ben Nager (for sleep complaint only)
- Consult with Dr. Tim Chrapkiewicz (must be referred by a sleep specialist)
- Diagnostic Sleep Study
- CPAP Titration
- (MSLT) Multiple Sleep Latency Test (must follow a Diagnostic Sleep Study)
- (MWT) Maintenance of Wakefulness Test
- Post Therapy Sleep Study (Oral Appliance, Surgery, CPAP)

DOCUMENTATION REQUIRED (Please fax to 847-854-7252)

- Recent Office Note (not necessary if referring to Dr Nager)
- Copy of patients insurance care (front and back); we will pre-authorize service coverage for patient

Physician Signature: _____ **Date:** _____