SLEEP CENTER OF MARIN REFERRAL FORM

Phone 415-878-0225 Fax 415-878-0215

Sleep Center
7100 Redwood Blvd, Suite 150
Novato, CA 94945

Main Clinic
100 Rowland way, Suite 300
Novato, CA 94945

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

DOB _____ Gender: ☐ M ☐ F Other_____ Marital Status ☐ S ☐ M ☐ D ☐ W

Street Address: _____ Apt/PO _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

PRIMARY INSURANCE _____ ID# _____ Group _____

Address _____ Phone _____

Subscriber _____ Guarantor _____ DOB _____

For **minors**, please add parent or legal guardian name: _____

THIS PATIENT IS BEING REFERRED FOR: (Please check all that apply)

- ☐ Sleep Consultation with Sleep Study (Sleep Specialist Consultation for evaluation, diagnostic testing and treatment.)
- ☐ Diagnostic polysomnogram (NoxA1s)
- ☐ Split Night polysomnogram
- ☐ PAP (Titration) polysomnogram: Adult, Pediatric (ages 4-13)
- ☐ Multiple Sleep Latency Test following Overnight Sleep Study
- ☐ Maintenance of Wakefulness Test
- ☐ Home Sleep Study (NoxT3s)

Clinical practice and testing will be performed according to the American Academy of Sleep Medicine guidelines.

PSG's and HST's are performed with wireless Nox Medical equipment by Board certified sleep technologists and interpreted by Board certified sleep physicians

SUSPECTED DISORDERS and Relevant Medical History: (Check all that apply)

- ☐ Obstructive Sleep Apnea
- ☐ Obesity with BMI > 45
- ☐ BMI< 30
- ☐ OSA treatment failure
- ☐ Narcolepsy
- ☐ Insomnia
- ☐ Central or Complex Sleep Apnea
- ☐ Moderate to severe pulmonary disease (pO2 <60 or pCO2>45)
- ☐ Neuromuscular disease (e.g. Parkinson's, spina bifida, myotonic dystrophy)
- ☐ Other critical health information _____
- ☐ Periodic Limb Movements (PLMs)
- ☐ Parasomnias/Nocturnal Seizures
- ☐ Upper Airway Surgery
- ☐ Stroke
- ☐ Epilepsy
- ☐ CHF

Prior Sleep Study:

- ☐ in lab PSG Date: _____
- ☐ HST Date: _____

Primary Care Physician: _____ Phone _____ Fax _____

Referring Physician:
Print Name: _____ Phone _____ Fax _____
Address
Reports will be sent here

Signature: _____ Date: _____

Please fax this form to 415-878-0215