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| Referral Request | | |
| Date: |  |

Thank you for your referral to the sleep clinic of Dr. Clifton Hunt, M.D. We look forward to working with you to provide the best care for your patient.

## Patient Information

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Name: |  |  | | Home Phone: | |  | |
| Date of Birth: |  |  | | Work Phone: | |  | |
| E-mail Address: |  | |  | | Cell Phone: | |  | |
| Primary Insurance: |  | |  | | Secondary Insurance: | |  | |

## Referral Information

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| --- | --- | --- | --- |
| Referring Doctor: | |  | |
| Office Address: | |  | |
| Office Phone: |  | | |
| Reason for Referral: | ☐ Sleep Apnea ☐ Insomnia ☐ Restless Legs ☐ Sleepiness ☐ Parasomnias | | |
|  | ☐ Other: | |  |

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| --- |
| Documentation *(please fax with this form)*  * Sleep study and/or polysomnogram results * Recent office notes * Proof of insurance |