

Sleep Center Consultation Request

Date of Request: _____ / _____ / _____

Thank you for choosing Salem Hospital Sleep Center. Your request is greatly appreciated.

Patient Information:

Patient Name: _____ Date of Birth: _____ / _____ / _____

SSN#: _____ - _____ - _____ Male Female

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____

Insurance Information:

Insurance Company: _____ Group Number: _____

ID Number: _____ Referral Auth #: _____

Number of Visits: _____ Start Date: _____ End Date: _____

Requesting Provider:

Physician Name: _____ Clinic: _____

Office Phone: _____ Fax: _____ Contact Name: _____

Instructions (Please include chart notes):

Sleep Disorders Evaluation & Treatment Consultation Request* Overnight Pulse Oximetry

Reason for Consultation/Evaluation:

Excessive daytime sleepiness Snoring Periodic Limb Movement Sleep Apnea
 Nocturnal hypoxemia Insomnia other

PHYSICIAN SIGNATURE: _____ DATE: _____

FAX: 503-561-4709

Phone: 503-561-5170

Please complete this form and fax along with chart notes. Your patient will be contacted within 24 hours and scheduled for testing and/or a consultation. A new patient sleep questionnaire and related materials will be mailed to the patient. Thank you for choosing Salem Hospital's Sleep Disorders Center.

*According to CMS guidelines 30.6.10, a consultation request is when a physician asks for, "advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional's knowledge."