REFERRAL TO DALLAS SLEEP BETTER SOLUTIONS

PATIENT FULL NAME _____ DATE OF BIRTH _____
ADDRESS_____
PHONE (s) HOME _____ OTHER _____
E-MAIL:_____

*Please fax a copy of patient's medical insurance card with this prescription

REFERRAL FOR

___ Home Sleep Study (CPT G0399 or 95800) And/Or

___ Oral Appliance (CPT E0486)-Dental Sleep Device

DESCRIPTION OF SYMPTOMS	**MEDICAL HISTORY**
___ Excessive daytime sleepiness ___ Fatigue ___ SOB ___ Snoring ___ Restless legs ___ Nocturnal seizures ___ Witnessed apnea ___ Restless sleep ___ Weight Gain ___ Gasping (if living alone) ___ Diaphoresis ___ Epworth Score _____ ___ Morning headaches ___ Enuresis ___ Other (explain) _____	___ CHF ___ Morbid Obesity ___ Stroke ___ Home O2 at ___ l/m ___ Diabetes ___ HTN ___ Seizures ___ Other-

Any condition or illness the staff should know: _____
Height: _____ Weight: _____ B/P: _____ Pulse: _____ Neck size: _____
Current list of Medications:_____
Allergies: _____
ORDERING PHYSICIAN:_____PHONE NUMBER:_____

SIGNATURE:_____ DATE: