TRANQUILITY SLEEP SPECIALISTS, PLC

www.tranquilitysleep.com

Referral Form for Evaluation, Diagnosis, and Treatment.

Complete this form and we will contact the patient to make an appointment.

TELEMEDICINE CONSULTATION

Patient Information:

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City: _____ State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____ **Email address:**

_____

Insurance Information:

Please send a copy of insurance card or fill in the information below:

Insurance: _____ Group#:_____ Policy#:_____

Policy Holder Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

Symptoms/Diagnosis:

Snoring (R06.83) Sleep Apnea (G47.33) Daytime Sleepiness (R40.0)

Restless Legs (G25.81) Narcolepsy (G47.411) Insomnia (G47.00)

Parasomnia (G47.50) Other: _____

Referring Physician Name: _____ NPI: _____

Office Contact: _____ Office Phone: _____ Fax: _____

PLEASE FAX A COPY OF YOUR PHYSCIAN'S ORDER, INSURANCE CARDS AND H&P OR LAST OFFICE NOTE as well as any previous sleep studies or records.

If no referring order is available please have the physician sign below indicating the need for this referral.

Signature: _____ **Date:** _____

Email completed form to mdobreski@utmck.edu or fax it to (888-381-3723).