uNITE Sleep Institute Referral Form

Phone: (702) 867-3508
Fax: 877-349-0238
Address: 3272 E. Sunset Rd. #100 Las Vegas, NV. 89120

PATIENT INFORMATION

Last Name: _____ First Name: _____

DOB: _____ Gender: _____ Marital Status: _____

Street Address: _____ MI: _____ SSN: _____

Apt/PO: _____ City: _____ Home Phone: _____ Work Phone: _____

State: _____ Zip: _____ Cell Phone: _____ Fax: _____

PRIMARY INSURANCE

Company: _____ ID#: _____ Group: _____

Address: _____ Phone: _____

Subscriber: _____ Guarantor: _____

DOB: _____ Employer: _____

THIS PATIENT IS BEING REFERRED FOR:

☐ New Patient Consultation ☐ Home Sleep Apnea Test

SPECIAL INSTRUCTIONS:

_____

_____

_____

SUSPECTED DISORDERS AND RELEVANT MEDICAL HISTORY: *(Check all that apply and include clinic notes)*

☐ Obstructive Sleep Apnea ☐ Central Sleep Apnea ☐ Daytime Fatigue

☐ Insomnia ☐ Cardiac Conditions ☐ Snoring Prior Sleep Study

☐ Narcolepsy ☐ Neurologic Disorder ☐ In lab PSG Date: _____

☐ Periodic Limb Movements (PLMs) ☐ COPD ☐ HST Date: _____

☐ Parasomnias/Nocturnal Seizures ☐ Morning Headache

REFERRING PROVIDERS INFORMATION

Provider Name: _____ Phone: _____ Fax: _____

Address: _____ NPI#: _____

_____ _____

Signature Date

Please include Patient Demographics, insurance card, and clinical notes documenting any comorbidities and the medical necessity of the sleep study.