Sonoran Sleep Center
5620 W. Thunderbird
Ste B3
Glendale, AZ 85306
P: (602) 206-6262
F: (602) 235-0296

Referral Form

PATIENT INFORMATION

Last Name:_____ First Name: _____ Middle Initial: _____

DOB: _____ Sex: _____ Male _____ Female

Cell Number: _____ Home Number: _____

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

REFERRING CLINICIAN INFORMATION:

Referred by: _____Title (MD/DO/NP/PA):_____

Phone: _____ Fax: _____

PCP (if different than referring clinician): _____

Address:_____

City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____

REASON FOR REFERRAL:

_____ OSA (G47.33) _____ Central Sleep Apnea (G47.31) _____ Sleep Apnea, unspecified (ICD10 G47.30)

_____ Snoring (ICD10 R06.83) _____ Hypersomnia (ICD10 G47.10)

_____ RLS (ICD10 G25.81) _____ Narcolepsy (ICD10 G47.419/G47.411 _____ Idiopathic Hypersomnia (ICD10 G47.11)

_____ Circadian Rhythm Disorder (ICD10 G47.20) Other: _____

Notes to Clinician:

_____

_____

_____

DOCUMENTATION REQUIRED (Please fax with this form) or email to: referrals@sonoransleep.com:

- Clinical Notes (include prior sleep study results if applicable)
- Proof of insurance
- Proof of Identification

Please give patient our business card or website information: **www.sonoransleep.com**. If the patient does not hear from us within 2 business days, they can call us at: **602-206-6262**.