Denali Asthma and Pulmonary

PATIENT REFERRAL FORM

Patient Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____ Phone: _____

☐ **Initial Consultation: Comprehensive patient evaluation for consideration of diagnostic polysomnography. Suspicious symptoms suggestive of obstructive sleep apnea:**

- O Observed Apneas
- O Loud Snoring
- O Frequent Awakenings
- O Excessive Daytime Sleepiness
- O Chronic Fatigue
- O Drowsy Driving
- O Choking or Gasping Awakenings
- O Falling Asleep at Inappropriate Times
- O Morning Headaches
- O Dry Mouth upon Awakening
- O Prior Diagnosis of Obstructive Sleep Apnea
- O Other _____

☐ **Re-Evaluation Consultation: Follow-up evaluation of patient with oral appliance for consideration of titration polysomnography and/or outcome polysomnography.**

Titration instructions: _____

_____

_____

Kindly keep me informed of the polysomnography results and my patient's progress.

Dentist's Signature: _____ NPI: _____ Date: _____

Printed Name: _____ Phone: _____ Fax: _____

Office Address: _____