8 Hour Sleep Clinic
(915) 875-1801
(915) 875-1516
7430 N. Mesa St. El Paso, Texas 79912
administration@8hoursleepclinics.com

PATIENT REFERRAL FORM

GENERAL PATIENT INFORMATION

Date of Request : ____/____/____

DOB : ____/____/____ Age: _____

Patient Name: _____

Gender: Male ☐ Female ☐

Patient SS#: _____

PATIENT INSURANCE INFORMATION

Address : _____

Primary Plan : _____ Policy ID#: _____

_____

Secondary : _____ Policy ID#: _____

Home Phone #: _____ Work #: _____

ORDERING PHYSICIAN CONTACT INFORMATION

Referring Physician: _____ Signature: _____

Phone Number: _____ Fax: _____

REQUEST FOR STUDY /PATIENT HISTORY

Symptoms: ☐ Insomnia ☐ Snoring ☐ Daytime Sleepiness ☐ Witnessed Apnea ☐ Abnormal Behaviors
☐ Headaches ☐ Other _____

PMH: ☐ HTN ☐ CVA ☐ Heart Disease ☐ Neuromuscular Disease ☐ Diabetes
☐ COPD ☐ Back Injury ☐ Headaches ☐ Other _____

Current Medications: _____

Patient with previous PSG or on CPAP : ☐ Yes ☐ No

Special Needs: _____

Is the patient on O_2? ☐ Yes ☐ No If yes, start study with __ or without __O_2?

Patient's Preferred Study Date : MON TUE WED THU FRI SAT SUN

APPOINTMENT INFORMATION

To Be Completed by 8 Hour Sleep Clinic Staff

Date: _____/_____/_____ **Time:** _____:_____ **AM/PM** **Initials:** _____

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