NEW PATIENT REFERRAL- *SLEEP DISORDER CENTER*

***Please *COMPLETE* and FAX this form to our office along with the following information:

- **LABS *within the past 6 months including* CBC,P33,TSH,B12,FOLATE,FERRITIN,IRON**
- **MEDICATION LIST**
- **PREVIOUS SLEEP STUDIES (5 YEARS TO CURRENT DATE)**
- **CURRENT OFFICE NOTES (INCLUDING THE REASON FOR THE REFERAL)**
- **HISTORY AND PHYSICAL (WITHIN THE PAST YEAR)**
- **ANY PULMONARY FUNCTION TESTS AND PULSE OX (IF APPLICABLE)**

*If a pre-authorization or an insurance referral is required for the consultation, we ask that you obtain this and it come with this referral.

Phone: 607-274-4617 ***Fax: 607-252-3422*** ***Email: sleepcenter@cayugamed.org***

Appointment Date/Time______________________________

Name______________________________ Social Security ______________
Last First init

Address______________________________ Home Phone______________

Email Address______________________________ **Cell Phone** ______________

City______________________________ State__________ Zip__________

Date of Birth__________ Age_____ Sex ☐ M ☐ F **Allergies**______________

Parent's Name if Minor______________________________Phone Number______________

Referred by Dr.______________________ Phone______________ Fax__________

Primary Care Dr. ______________________ Phone______________ Fax__________

Reason for referral ☐ Snoring ☐ Apnea ☐ Difficulty initiating sleep ☐ Difficulty maintaining sleep ☐ HTN

☐ Other______________________________

PRIMARY INSURANCE

Subscriber Name______________________________
Relationship to Patient______________________ Date of Birth__________ SS# __________
Address if Different from Patient______________________________ Phone #__________
Insurance Company______________________________ Phone ______________
Address______________________ City__________ State__________ Zip__________
Subscriber ID #______________________ Group # (if applicable)______________
Referral Number ______________________________