Date: _____

Patient Information

Last Name: _____ First Name: _____

DOB: ___ / ___ / ___

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Email Address: _____

Physician Information

Referring Practice: _____

Ph: _____ Fax: _____

Referring Doctor: _____

Dr. Signature: _____

Please select one of the following options:

SLEEP SERVICES

OUR sleep physician will manage patient's care for their sleep health.

❍ **Telehealth & Treat** (includes the following)
- Initial telehealth visit with our sleep physician
- Telehealth visit after testing to go over results and treatment options
- Additional testing and/or CPAP setup if recommended
- Ongoing management of care

❍ **HST & Treat** (includes the following)
- Home Sleep Test (Includes both Central Apnea and Obstructive Apnea Diagnoses)
- Telehealth visit after testing to go over results and treatment options
- Additional testing and/or CPAP setup if recommended
- Ongoing management of care

SLEEP STUDY ONLY

YOU will manage patient's care for their sleep health.

❍ **Home Sleep Test (can diagnose both Obstructive and Central Apnea)**

PAP EQUIPMENT ONLY

❍ **Auto-PAP** w/supplies

Max Pressure _____ cmH20

Min Pressure _____ cmH20

❍ **CPAP** w/supplies

Pressure _____ cmH20

❍ **BiPAP S/ST** w/supplies

Max Pressure _____ cmH20

Min Pressure _____ cmH20

PS _____ (If ST Needed)

❍ **CPAP Mask & Supplies**

parkway SleepHealth centers

Sound sleep. Sound health.

Referral Form

Fax this form to 919.462.8082 along with a copy of:

- Patient Demographics
- Medical History/Medications
- Insurance Card
- Notes from Referring Provider
- Any Previous Sleep Testing

Parkway will verify insurance eligibility, obtain authorization, contact and schedule the patient.

Contact Us:

919-423-4161

919-462-8082

parkwaysleep.com

cdavis@parkwaysleep.com