Sleep Innovations

SLEEP SPECIALTY CLINIC

NEW PATIENT REFERRAL/CONSULT FAX FORM

Please complete the following form and return along with records and insurance cards via fax to 800-861-9623. Thank you for your referral.

PROVIDER'S INFORMATION	
Today's Date:	Referring Provider:
Person Making Referral:	**Fax Number:**
Reason for Referral/Consultation: ☐ SLEEP APNEA ☐ CONSULT FOR SLEEP STUDY AND SLEEP MANAGEMENT ☐ OTHER (PLEASE SPECIFY) ☐ HOME SLEEP TEST ☐ INSOMNIA	
PATIENT'S INFORMATION	
Name:	Date of Birth:
Address:	
City: State:	Zip:
Cell Phone:	Home/Work:
Primary Insurance:	ID #
Secondary Insurance:	ID #
Insurance Referral/Authorization #	
****PLEASE SEND A COPY OF THE PRIMARY & SECONDARY INSURANCE CARDS***	

Please Provide the Following Required Documents:

- ☐ Current Office Note (From last office visit/talking about issue)
- ☐ Medication List
- ☐ Sleep Studies
- ☐ Copies of Insurance Cards (front and back)
- ☐ Download/Compliance Report (if currently on machine)

2882 AAA Court Bettendorf, IA 52722 Ph # 563-341-7378 Fax # 800-861-9623