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| Referral Request |
| Date: |  |

Thank you for your referral to the sleep clinic of Dr. Clifton Hunt, M.D. We look forward to working with you to provide the best care for your patient.

## Patient Information

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| --- | --- | --- | --- | --- |
| Patient Name: |  |  | Home Phone: |  |
| Date of Birth: |  |  | Work Phone: |  |
| E-mail Address: |  |  | Cell Phone: |  |
| Primary Insurance: |  |  | Secondary Insurance: |  |

## Referral Information

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| Referring Doctor: |  |
| Office Address: |  |
| Office Phone: |  |
| Reason for Referral: | ☐ Sleep Apnea ☐ Insomnia ☐ Restless Legs ☐ Sleepiness ☐ Parasomnias |
|  | ☐ Other: |  |

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| Documentation *(please fax with this form)** Sleep study and/or polysomnogram results
* Recent office notes
* Proof of insurance
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