BEL-RED SLEEP
DIAGNOSTIC CENTER

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Phone: (425) 451-8417 Fax: (425) 455-4089
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☐ Dr. Stanley Chen

REFERRAL FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____MI_____ Gender: ☐ Male ☐ Female

D.O.B_____ SSN #:_____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Street Address: _____City: _____State:_____Zip:_____

Phone:(Home)_____(Work)_____(Cell)_____

PRIMARY INSURANCE _____ID#_____Group_____

Subscriber Name (if different from patient): _____

SYMPTOMS: (Check all that apply)

☐ Snoring ☐ Apnea/gasping ☐ Fatigue/Sleepiness ☐ Hypoxemia ☐ Insomnia ☐ Hypertension ☐ Stroke

☐ Arrhythmia ☐ Restless Legs ☐ Other: _____

All testing will adhere to American Academy of Sleep Medicine Practice Parameters. For Medical documentation and to satisfy insurance guidelines for reimbursement, adequate baseline data and sleep time will be collected before attempting treatment intervention. Split-night studies will be performed whenever appropriate.

*****PLEASE ATTACH RECENT H&P PERTINENT TO THE SLEEP TEST *****

Referring Physician:_____Phone: _____Fax:_____

Signature: _____Date: _____NPI #:_____

Note to Physician: The sleep study results will be faxed or mailed to the referring physician's office. **Please allow at least 3 business days for the test results. For your patient's privacy please be sure that the fax number you provide is correct. **