

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 _____ cmH2O

Min Pressure _____ cmH2O

☐ **CPAP** w/supplies

Pressure _____ cmH2O

☐ **BiPAP S/ST** w/supplies

Max Pressure _____ cmH2O

Min Pressure _____ cmH2O

PS _____ (If ST Needed)

☐ **CPAP Mask & Supplies**



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



info@parkwaysleep.com