



3920 Lake Otis Pkwy Suite 1, Anchorage, AK 99508 Phone: (907) 770-9104 Fax: (907) 770-8965

Sleep Study/Consult Order

Patient Name _____ Date _____

Address _____

Home Phone _____ Work Phone _____

Sleep Disorders Referral

An initial consultation with a Board Certified Sleep Disorders Physician for evaluation with services to include diagnostic testing, treatment, and follow up of sleep disorder as indicated.

Please indicate reason(s) for referral

- | | | |
|---|---|---|
| <input type="radio"/> <i>Witnessed Apneas</i> | <input type="radio"/> <i>Frequent Awakenings</i> | <input type="radio"/> <i>Cataplexy and Narcolepsy</i> |
| <input type="radio"/> <i>Excessive Daytime Sleepiness</i> | <input type="radio"/> <i>Violent behavior when asleep</i> | <input type="radio"/> <i>Sleep Walking</i> |
| <input type="radio"/> <i>Snoring</i> | <input type="radio"/> <i>Poor Memory / Cognition</i> | <input type="radio"/> <i>Nighttime Seizures</i> |
| <input type="radio"/> <i>Restless Legs / Periodic Movements</i> | <input type="radio"/> <i>Morning headaches</i> | <input type="radio"/> <i>Insomnia</i> |
| <input type="radio"/> <i>Other: _____</i> | | |

Physician Signature _____ Date _____

Printed Physician Name _____ Date _____

Address _____

Phone _____ Fax _____

*Please fax copies of patient's medical history, current medications,
and insurance card with referral to (907) 770-8965*

Thank you!