MelioREM
Your Source For Optimal Sleep

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Tel: (775) 557-4900 **Secure Fax**: (833)989-2134

SLEEP SERVICES REFERRAL FORM

DATE:_____

PATIENT INFORMATION:

Name:_____ D.O.B._____

Home Ph#_____ SS# _____

Address:_____

Employer:_____ Cell Ph# _____

REASON FOR REFERRAL:

____ Obstructive Sleep Apnea (G47.33) ***Please check all symptoms that apply****:*

☐ Snoring ☐ Witnessed Apnea ☐ Unrefreshing sleep ☐ Fatigue ☐ Daytime Sleepiness

____ Periodic Limb Movements (G47.61) ____ Restless Legs (G25.81) ____ Insomnia (F51.01)

____ REM Behavior Disorder (G47.52) ____ Somnambulism (F51.3) ____ Narcolepsy (G47.411)

____ Other: _____

_____

SERVICES REQUESTED:

___ Consult and Sleep Study (if indicated)

___ Other (please specify) _____

___Sleep Study Only(Home Sleep Test/ In-lab sleep study)_____

REFERRING PROVIDER:_____ Phone:_____

Address:_____ Fax:_____

Provider Signature X_____

PLEASE INCLUDE:

- ☐ **Insurance Information**
- ☐ **Medical History, recent clinic note and lab result**
- ☐ **Medications List**

Please FAX form to:(833) 989-2134 for In-person appointment
(833) 974-2028 for Telehealth appointment