



DR DANIEL ROOT ~ DR JENNIFER KIM
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PHYSICIAN DIRECT REFERRAL FORM

OSA STRONGLY ENCOURAGES ALL REFERRED PATIENTS TO HAVE A CONSULTATION WITH OUR SLEEP SPECIALIST PRIOR TO SCHEDULING A STUDY. HOWEVER, IF THE REFERRING DOCTOR ORDERS A SLEEP STUDY ONLY, OSA REQUIRES A COPY OF PATIENT'S H&P, CHART NOTES, AND INSURANCE CARD WITH THIS FORM

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

HOME PHONE: _____ ALT #: _____

AGE: _____ HT: _____ WT: _____ GENDER: M / F

INDICATIONS FOR CONSULTATION AND EVALUATION

- | | |
|--|--|
| <input type="checkbox"/> SNORING | <input type="checkbox"/> HEADACHES |
| <input type="checkbox"/> DAYTIME SLEEPINESS | <input type="checkbox"/> HYPERTENSION |
| <input type="checkbox"/> OBSERVED APNEAS | <input type="checkbox"/> MORBID OBESITY |
| <input type="checkbox"/> FREQUENT AWAKENINGS | <input type="checkbox"/> BARIATRIC SURGERY |
| <input type="checkbox"/> INSOMNIA | <input type="checkbox"/> NOCTURNAL REFLUX |
| <input type="checkbox"/> LEG/LIMB MOVEMENTS | |
| <input type="checkbox"/> OTHER: _____ | |

TYPE OF STUDY (CONSULTATION WILL BE DONE UNLESS "STUDY ONLY" IS MARKED)

- | | |
|---|---|
| <input type="checkbox"/> DIAGNOSTIC PSG | <input type="checkbox"/> PAP TITRATION |
| <input type="checkbox"/> SPLIT NIGHT PSG | <input type="checkbox"/> CHECK FOR <i>STUDY ONLY</i>
(No CONSULTATION OR FOLLOW-UP) |
| <input type="checkbox"/> CPAP/ MASK EQUIPMENT SERVICES ONLY | |
| <input type="checkbox"/> <i>FREE</i> OVERNIGHT HOME OXIMETRY (No CONSULTATION OR SLEEP STUDY UNLESS OTHERWISE REQUESTED) | |
| <input type="checkbox"/> PORTABLE OVERNIGHT TESTING | |

SPECIAL INSTRUCTIONS OR INFORMATION

REFERRING PHYSICIAN'S INFORMATION

NAME: _____ CONTACT: _____

ADDRESS: _____

OFFICE PHONE: _____ FAX: _____

PHYSICIAN'S SIGNATURE: _____ DATE _____

FAX THIS FORM TO (503)288-0151