SLEEP CENTERS
OF NORTH ALABAMA

Phone: (256) 384-2408 | Fax: (256) 203-6464

REFERRAL FORM

Patient Information

Full Name: ____________________ **Date of Birth:** ________ **SSN:** ________

Address: ______________________________ **Phone:** _______________

Email Address: ____________________ **Insurance:** ____________________

Referring Physician: ______________________________

Physician Phone: _______________ **Physician Fax:** _______________

Symptoms

❒ **Sleep Apnea**	❒ **Daytime Sleepiness**	❒ **Hypoxia**
❒ **Snoring**	❒ **Narcolepsy**	❒ **Night Terrors**
❒ **EKG Arrhythmias**	❒ **Insomnia**	❒ **Sleep Talking/Walking**
❒ **Seizures**	❒ **Myoclonus/Restless Legs**	❒ **Other, please specify:** _______________

Please include/attach the following when sending your referrals to SCNA:

- Driver’s License
- Documentation of Symptoms
- BMI
- Prior Sleep Study Reports (if available)
- Insurance Cards
- Epworth Sleepiness Score
- Neck Circumference

This referral form may be sent to our office via email at office@sleepnorthal.com or fax at 256-203-6464. Our staff will then contact the patient directly to schedule their appointment. After they complete an office visit with our sleep specialist, we will forward a copy of their consultation to your office. Sleep study reports will be sent to your office upon completion.

❒ **In-Lab Sleep Test (Preferred)** ❒ **Home Sleep Test (Preferred if qualified)**

Physician’s Signature: _________________________ **Date:** ____________

SLEEP CENTERS OF NORTH ALABAMA   SLEEP MD   SLEEP SOUTH DIAGNOSTICS

Providing Sleep Management Across Alabama

Huntsville ● Decatur ● Cullman ● Birmingham ● Montgomery
Prattville ● Dothan ● Auburn ● Anniston