SLEEP CENTERS
OF NORTH ALABAMA

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:** ______________

Huntsville - 1101 McMurtrie Dr, Suite H1 Decatur - 1304 13th Ave SE, Suite E

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