SLEEP SOUTH DIAGNOSTICS

Phone: (334) 396-8082

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 mike.waites@gmail.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:** _____