# *Sleep Medicine Associates*

7103 Bakers Bridge Ave. 102
Brentwood TN, 37027
P – 615-732-5712   F – 615-634-8350

## *Referral to Sleep Medicine Associates*

Patient Name_________________________________________ SS#___________________________ DOB_________

Patient Address__________________________________________City&State___________________Zip___________

Daytime Phone___________________Cell Phone__________________Altenate Contact________________________

Patient Employer & Number_________________________________________________________________________

Primary Insurance_____________________________ ID#________________________Group#__________________

Secondary Insurance___________________________ID#________________________ Group#__________________

Patient Sex ____________Height___________ Weight__________________ Neck Size________________________

**Provider Information**

Referring Provider __________________________________________ NPI ____________________________

Provider's Address__________________________________

Phone (____) _______________________________ Fax(____)__________________________________

**Suspected Disorder**

____Sleep Apnea ____ Narcolepsy ____ Parasomnias/Seizures ____ Periodic Limb Movement ____ ther(specify)________

*I certify that that this referral of the above patient to SMA and/or TMA is strictly to provide information to assist in my diagnosis.*

*This test and its interpretation are intended to supplement my diagnosis and is medically necessary. I understand SMA and/or*

*TSM will not provide a diagnosis for this patient's condition. I am aware the patient may require two sleep studies and will be*

# *Sleep Medicine Associates*

7103 Bakers Bridge Ave. 102
Brentwood TN, 37027
P – 615-732-5712 F – 615-634-8350


*scheduled for the second study if the SHI/RDI meets criteria to indicate CPAP titration.*

**Signature**________________________________________ Date:____________________

**PLEASE FAX ORDER AND PROGRESS NOTES TO (615) 634-8350**