



# Referral Request Form

Please fax to (512) 328-2455.

David R. Duhon, M.D.

Date: \_\_\_/\_\_\_/\_\_\_ Referring Physician: \_\_\_\_\_ Phone: ( \_\_\_ ) \_\_\_ - \_\_\_\_\_

Patient's Name	Social Security #	Date of Birth
Home Phone	Alternate Phone	
Address	City, State, Zip	

**CHIEF COMPLAINT(S) OF PATIENT (CHECK ALL THAT APPLY)**

Snoring/Sleep Apnea     
  Excessive Daytime Sleepiness     
  Circadian Rhythm Disorder  
 Night Terrors     
  Insomnia     
  Sleep Walking/Talking/Eating  
 Possible Narcolepsy     
  Restless Legs Syndrome     
  Other: \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Carrier:	Insured (please circle one): Self      Spouse      Child      Other
Policy/Group #:	Insured's Name and DOB (if different from patient)
Subscriber #:	Insured's Employer
Customer Service #:	Referral / Pre-Cert Number (if required)

**PLEASE SELECT ONE OF THE FOLLOWING REFERRAL OPTIONS**

- I. Consult with a center physician for evaluation and ongoing management, including initiation and management of CPAP therapy if obstructive sleep apnea is diagnosed **(preferred)**
  
- II. Direct Sleep Study – Patient will not meet with our physicians. The referring physician maintains the care of the patient by initiating the treatment plan and following the patient's progress. **Please review/provide the following information:**
  - Specify the type of direct sleep study:
    - Diagnostic study (CPAP may be applied urgently, per protocol)
    - Split night study (criteria for obstructive sleep apnea must be met)
    - CPAP / BI – LEVEL all night titration study  
**(diagnostic criteria from previous sleep study must be on file)**
  
  - Send a recent H & P.\*

*\*In order to uphold our center's accreditation with The American Academy of Sleep Medicine it is required that we obtain a recent History and Physical for all patients referred for a direct sleep study. We appreciate your understanding.*