PLEASE CIRCLE LOCATION IF PATIENT HAS PREFERENCE

Midtown:	**East:**	**Gibson:**	**Henderson:**
350 W. Columbia St.	7307 E. Columbia St.	1808 Sherman Dr.	1305 N Elm St.
Evansville, IN 47710	Evansville, IN 47715	Princeton, IN 47670	Henderson, KY 42420
Phone: 812-450-5025	Phone: 812-450-1543	Phone: 812-385-1705	Phone: 270-827-7474

SLEEP CENTER CONSULTATION REQUEST FORM

Patient Name: ____

Patient Address: ____

City: ___________________________________ State: __________________ Zip Code: _________________

Patient Phone #: ____ SS#: _____________________

Alternate Phone #: ____ DOB: _____________________

Symptoms (check all that apply):

□ Snore □ Choking or Gasping □ Fatigue

□ Witnessed Apneas □ Excessive Daytime Sleepiness □ Restless Legs

□ Insomnia □ Sleep Talking or Walking □ Shift Work Sleep Disorder

□ Sleep Terrors □ Bruxism □ REM Behavior Disorder

□ Memory loss/ poor concentration

□ Other: ____

Other co-morbidities (check all that apply):

□ Hypertension □ Diabetes □ Obesity □ Stroke (CVA)

□ CHF □ CAD □ Mood Disorder

Previously diagnosed with OSA? Y N If yes, is patient currently on CPAP? Y N

Is this request for a sleep study for pre-op evaluation prior to bariatric surgery? Yes No

Is the patient a commercial driver? Yes No

Height: ______ Weight: ______ BMI: ______

Please return a copy of the patients History & Physical, list of current medications, allergies and insurance card(s) along with this form to **(812)-473-2432** and we will contact your patient to schedule their appointment.

Referring Provider: ____

Date: _______________________ Phone: ____________________________ Fax: ___________________________