



Sleep Center of
kentuckiana

SLEEP CENTER OF KENTUCKIANA

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Louisville, KY 40219
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PULMONARY AND SLEEP MEDICINE

Referral Form

Please fill out the information below and fax it to (866) 845-0491.

Today's Date: _____ Referring Physician Signature: _____

Type of referral: Sleep Test Pulmonary Medical Equipment



PATIENT INFORMATION

Patient Name:	Date of Birth:	Social Security #	
Home Phone:	Cell Phone:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Patient Address:	City:	State	Zip Code

Chief Complaint(s) of patient (*check all that apply*):

- | | | |
|--|---|--|
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Circadian Rhythm Disorder | <input type="checkbox"/> Lung Infection (Pneumonia) |
| <input type="checkbox"/> Snoring/Sleep Apnea | <input type="checkbox"/> Night Terrors | <input type="checkbox"/> Blocked Lung Artery (Pulmonary Embolus) |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Sleep walking/talking/eating | <input type="checkbox"/> Swelling & Inflammation (Bronchitis) |
| <input type="checkbox"/> Possible Narcolepsy | <input type="checkbox"/> COPD | <input type="checkbox"/> Collapse of part or all lung |
| <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Asthma | <input type="checkbox"/> Build up of fluids in lungs (Pulmonary Edema) |
| <input type="checkbox"/> Sleep walking/talking/eating | <input type="checkbox"/> Lung Cancer | |
| <input type="checkbox"/> Other (please specify): _____ | | |

INSURANCE INFORMATION

You can either fill out the information below or fax a legible copy of the insurance card along with this form.

Name of Insurance Company: _____

Type: HMO PPO EPO POS Other: _____

Primary Card Holder's Name: _____

Member ID number: _____

Customer Service #: _____

Referral #: _____

(Passport or essence referral required)

**WE ACCEPT ALL
INSURANCE**



PASSPORT ID 50019439