Dartmouth-Hitchcock
MEDICAL CENTER

Physician Connection Line
Phone: 1-866-DHMC DOC
(866) 346-2362

Fax form to:
Fax: (603) 676-4080

Referral Form
Sleep Disorders Center

Please indicate preference: ❒ **DHMC Referral** ❒ **CVH Referral** Today's date: _____

Patient name: _____ DOB: _____ SSN: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Mailing address: _____

Parent/guardian: _____

Insurance provider: _____ Insurance policy #: _____

Insurance phone number: _____ Insurance referral submission date: _____

Subscriber's name: _____ Subscriber's SSN: _____

Referring provider: _____ Contact person: _____

Office phone: _____ Office fax: _____

Primary care physician (if different from above): _____

Contact person: _____

Primary care physician phone: _____ Primary care physician fax: _____

Sleep Disorders Center Referral Information

Reason for referral: _____

_____

Prior PSG: ❑ No ❑ Yes When _____ (please forward copy) Height: _____ Weight: _____

Signs and symptoms: (check all that apply)

❑ Observed apnea ❑ Daytime sleepiness ❑ Snoring ❑ CHF ❑ Periodic limb movements ❑ Insomnia
❑ Restless legs ❑ Morning headaches ❑ COPD ❑ High BP ❑ Parasomnia (e.g. sleepwalking)

Medical conditions:

Using Oxygen: ❑ No ❑ Yes _____ lpm ❑ Nighttime ❑ Continuous ❑ Tracheotomy

Physically disabled: ❑ No ❑ Yes (explain) _____

Developmentally disabled: ❑ No ❑ Yes (explain) _____

Other medical conditions: _____

_____

Sleep Disorders Center Office Use Only

Patient MR#: _____ ❑ **PSG consult** ❑ **Insomnia consult** ❑ **Other:** _____

Date referral received: _____ Date sent for verification: _____ Date verification received: _____

Referral needed: Consult ❑ No ❑ Yes Date sent: _____
PSG ❑ No ❑ Yes Date sent: _____

Authorization needed: Consult ❑ No ❑ Yes Authorization #: _____
PSG ❑ No ❑ Yes Authorization #: _____

Contact #1: _____ Contact #2: _____ Letter sent: _____ Consult appointment date: _____