



UNC Hospitals Sleep Disorders Center Referral Form

Please fax back the referral form, demographic sheet and clinic notes to **984-974-1668**. If you have any questions call the sleep lab at **984-974-3294**.

- | | |
|--|---|
| <input type="checkbox"/> Polysomnography (PSG) | <input type="checkbox"/> Polysomnography with CPAP/BIPAP (If the patient has not had a recent PSG, then a Standard PST will need to be ordered) |
| <input type="checkbox"/> Home Sleep Study (HST) | |
| <input type="checkbox"/> Maintenance of Wakefulness Test (MTW) | <input type="checkbox"/> Multiple Sleep Latency Test (MSLT) |
| <input type="checkbox"/> ASV | <input type="checkbox"/> Actigraphy |
| | <input type="checkbox"/> Parasomnia Protocol |

PATIENT INFORMATION: Please fill out information below and include demographic sheet.

Name _____ UNC MRN # _____ DOB _____

Street Address _____ City _____ State _____ Zip _____

Preferred Language _____ Interpreter Needed? Yes No

Gender _____ Age _____ Race _____ Pt's Phone Number: _____

Primary Insurance _____ Insurance ID# _____

Secondary Insurance _____ Insurance ID# _____

Referring Physician _____ Phone _____ Fax _____

Reason for Referral:

Diagnosis Codes:

Special Instructions: