UNC Hospitals Sleep Laboratory Referral Form

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

- ☐ Polysomnography (PSG)
- ☐ Home Sleep Study (HST)
- ☐ Maintenance of Wakefulness Test (MTW)
- ☐ ASV
- ☐ Polysomnography with CPAP/BIPAP (If the patient has not had a recent PSG, then a Standard PSG will need to be ordered)
- ☐ Multiple Sleep Latency Test (MSLT)
- ☐ Actigraphy
- ☐ 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: _____

*Guarantor's Name: _____ *Guarantor's DOB:_____*Relationship:_____

(*__**REQUIRED**__ for all patients under 18 years of age. WE CANNOT TRANSCRIBE AN ORDER WITHOUT THIS INFORMATION.)

Primary Insurance_____ Member ID#_____

Secondary Insurance_____ Member ID#_____

Referring Physician_____Phone_____ Fax_____

Reason for Referral_____

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Diagnosis Codes_____

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Special Instructions_____

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