TOTAL SLEEP
VESTAVIA

Total Sleep, LLC
100 Centerview Drive, Suite 240
Vestavia Hills, Alabama 35216
(205) 878-3360 Phone
(205) 878-3361 Fax

PATIENT NAME: _____DATE: _____

DATE OF BIRTH: _____/_____/_____. PHONE: _____ or _____

INSURANCE: _____POLICY # _____ GROUP # _____

Check one:

_____ I would like my patient to be **scheduled for an immediate sleep study.** Office notes, insurance information and demographics are included with this fax.

_____ I would like my patient to be evaluated by a Sleep Physician for possible sleep disorders.

_____ This patient has a previous diagnosis of Sleep Apnea and is in need of re-evaluation.

CHIEF COMPLAINT

PLEASE CIRCLE ALL THAT APPLY:

Snoring Excessive Daytime Sleepiness Witnessed Apnea Stops Breathing During Sleep

Leg Movements during Sleep Cognitive Impairments Gasping for Air During Sleep

Difficulty Sleeping Headaches Non-Restorative Sleep Other: _____

HISTORY

PLEASE CIRCLE ALL THAT APPLY:

High Blood Pressure	Asthma	Insomnia	Narcolepsy
Emphysema	COPD	Depression	Stroke
Chronic Bronchitis	Heart Arrhythmias	Diabetes	Anxiety
Restless Leg Syndrome	Heart Disease	Congestive Heart	Obesity

Please fax this completed form along with the patient's demographics, office notes and insurance information to (205) 878-3361 Fax

Check one:

_____ **In-Lab Sleep Study(Preferred)** _____**Home Sleep Test (preferred if qualified)**

_____ _____ _____

REFERRING PHYSICIAN SIGNATURE DATE Reviewed by Gerald Dey, MD FACS