



REFERRAL FORM
DATE _____

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PATIENT INFORMATION:

LAST NAME FIRST NAME M.I. SEX DATE OF BIRTH

REFERRING PHYSICIAN PRIMARY CARE PHYSICIAN

CHIEF COMPLAINT DIAGNOSIS CODE(S)

PRIMARY INSURANCE SUBSCRIBER I.D. GROUP NUMBER

SECONDARY INSURANCE SUBSCRIBER I.D. GROUP NUMBER

**IF PRIOR AUTHORIZATION IS REQUIRED BY PATIENT'S INSURANCE, PLEASE OBTAIN
PRIOR TO SENDING REFERRAL.**

IS PRIOR AUTHORIZATION REQUIRED? Y/N

IF YES, AUTHORIZATION NUMBER _____

SLEEP STUDIES MUST BE ORDERED BY DR. SHIM. IS THIS REFERRAL FOR (CIRCLE ONE):

SLEEP DISORDER EVALUATION AND TREATMENT OVERNIGHT PULSE OXIMETRY

REFERRING PHYSICIAN SIGNATURE DATE

*THANK YOU FOR CHOOSING SALEM SLEEP MEDICINE. PLEASE FAX US A REFERRAL FORM ALONG
WITH CHART NOTES AND PATIENT DEMOGRAPHICS TO THE NUMBER AT THE TOP OF THE FORM
AND WE WILL CONTACT THE PATIENT TO SCHEDULE AN APPOINTMENT.*