PLEASE COMPLETE & FAX TO: (803) 630- 1529
OR E-MAIL FORM TO: bettersleepbydesign@gmail.com

KAREN E. JOHNSON, D.D.S., M.H.S
2757 Laurel St, Suite 1, Columbia, SC 29204
TEL: (803) 630-1189

REFERRAL FORM

PATIENT'S FULL NAME ____

DATE OF BIRTH: ____

ADDRESS____

*PHONE NUMBER(S) CELL _______________________ OTHER ___________________________________

*EMAIL ADDRESS____

REFERRING PHYSICIAN'S NAME: ____

PHONE NUMBER: ____________________________ FAX: ________________________________

PHYSICIAN'S EMAIL ADDRESS: ____

TAX ID: ____________________NPI: ________________________________

INSURANCE NAME: ____
POLICY #: ____
GROUP #: ____

PRESCRIPTION FOR AT-HOME SLEEP TEST

PATIENT'S HISTORY & PRESENTING SYMPTOMS

- ❑ Snoring
- ❑ Witnessed Apnea
- ❑ Morning Headaches
- ❑ Daytime Sleepiness
- ❑ Nocturia
- ❑ Fatigue
- ❑ Obesity (BMI:_______)
- ❑ Diabetes
- ❑ Hyperension
- ❑ Other:___________________________________

CURRENT CPAP User ❑YES OR ❑NO
PREVIOUS CPAP User ❑YES OR ❑NO
Last Sleep Test Date (if applicable): ____

SUSPECTED DIAGNOSIS:

- ❑ Obstructive Sleep Apnea (OSA)
- ❑ Insomnia
- ❑ Excessive Daytime Sleepiness
- ❑ Restless Legs Syndrome (RLS)
- ❑ Narcolepsy
- ❑ Snoring
- ❑ Other:____________________

❑ TESTING CONSULTATION & TREATMENT MANAGEMENT
(Once the study is completed, a Board-Certified Sleep Physician will review the Results and Better Sleep By Design will Review with the patient at a consultation appointment after the study.)

PHYSICIAN'S SIGNATURE: _______________________________________ DATE: ________________