



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

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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: _____

SUSPECTED DIAGNOSIS:

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

CURRENT CPAP User YES OR NO

PREVIOUS CPAP User YES OR NO

Last Sleep Test Date (if applicable): _____

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: _____