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 4, 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
- ❑ Hypertension
- ❑ 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:** _____