WESTSIDE SLEEP CENTER
SCOTT D. FROMHERZ, MD
7450 SW BEVELAND ST, SUITE 120, TIGARD, OR 97223
PHONE: (503) 639-7000 FAX: (503) 639-7006

REFERRAL FORM

Please complete the following information and return by fax. Submit pertinent medical history and a **copy of the patient's insurance card** (both sides). Thank you for your referral.

step1 PATIENT

LAST NAME | FIRST | MIDDLE

STREET | CITY | STATE | ZIP

PHONE | ALTERNATE PHONE

DOB | HT | WT | GENDER (M) (F)

step2 REFERRING PHYSICIAN

LAST NAME | FIRST | NPI

STREET | CITY | STATE | ZIP

PHONE | FAX

step3 WHY REFERRING

◯ Snoring ◯ Observed Apnea ◯ Daytime Sleepiness ◯ Insomnia ◯ AM Headaches ◯ Gasping ◯ Narcolepsy

◯ Restless Legs ◯ Nighttime Limb Movements ◯ Frequent Awakenings ◯ Sleep Walking ◯ Unrefreshing Sleep

◯ Sleep Paralysis ◯ Shift Work D/O ◯ Night Hallucinations ◯ Circadian Rhythm D/O ◯ Other: _____

Prior Diagnosis of Sleep Apnea: ◯ Yes ◯ No ◯ When _____ ◯ AHI _____

step4 SELECT ONE SERVICE OPTION

◯ OPTION 1

Full Sleep Evaluation:
Consultation by Sleep Specialist, Necessary Testing, Therapy, Equipment, and Sleep Related Follow-up

◯ OPTION 2

Sleep Study and Follow-up:
Westside Sleep Provides Sleep Apnea Follow-up & Equipment

◯ OPTION 3

Sleep Study Only:
Ordering Physician Provides Follow-up

CHOOSE TYPE OF STUDY

◯ Standard Polysomnogram *(Split Night if Indicated)* ◯ CPAP/BiPAP titration

Note: *(MSLT/MWT available, requires consult)*

step5 SIGN + DATE + FAX

PHYSICIAN SIGNATURE | DATE

Please fax to: (503) 639-7006