




Covenant Sleep Centers

<input type="checkbox"/> Evaluate, Diagnose & Treat at:	<input type="checkbox"/> Evaluate, Diagnose & Treat at:	<input type="checkbox"/> Evaluate, Diagnose & Treat at:	<input type="checkbox"/> Evaluate, Diagnose & Treat at:	<input type="checkbox"/> Evaluate, Diagnose & Treat at:
 FORT SANDERS REGIONAL MEDICAL CENTER	 Parkwest MEDICAL CENTER	 ROANE MEDICAL CENTER <small>Covenant HEALTH</small>	 METHODIST MEDICAL CENTER OF OAK RIDGE	 LECONTE MEDICAL CENTER <small>Covenant HEALTH</small>
865.541.1375 Fax: 865.541.1714	865.373.1974 Fax: 865.373.1059	865.882.4107 Fax: 865.882.4449	865.835.3810 Fax: 865.835.3811	865.446.7625 Fax: 865.446.7626

PATIENT INFORMATION

First Name:		Last Name:		MI:
SSN:		DOB:	Wt:	Ht:
Address:		City:	State:	Zip:
Home Phone:		Work Phone:	Other:	

INSURANCE INFORMATION

Insurance:		Group#:	Policy#:
Address:		City:	State: Phone:
Policy Holders Name:		Relation to Patient:	

PHYSICIAN INFORMATION

Referring Physician:	Physician Phone:	Fax:
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PRELIMINARY DIAGNOSIS / IMPRESSION / PATIENT COMPLAINT

<input type="checkbox"/> Snoring (786.09)	<input type="checkbox"/> Periodic Limb Movements (327.51)	<input type="checkbox"/> Nocturnal Seizures (345)
<input type="checkbox"/> Insomnia (307.42)	<input type="checkbox"/> Apnea/UARS (327.23)/Prior Dx	<input type="checkbox"/> Sleep talking, walking, eating (or other)
<input type="checkbox"/> Daytime Sleepiness (780.54-7)	<input type="checkbox"/> Narcolepsy (347.00)	<input type="checkbox"/> REM Behavior Disorder (327.42)
<input type="checkbox"/> Morning Headaches	<input type="checkbox"/> Frequent Awakenings	<input type="checkbox"/> Waking up gasping/not breathing
<input type="checkbox"/> Restless Legs (333.94)	<input type="checkbox"/> Other _____	

Dear Physician: Your patient has selected one of the Covenant Sleep Centers to determine the presence of a sleep disorder. As you know, CMS/Medicare permits a patient to choose his or her provider freely. At your earliest convenience, please fax:

- This completed Referral Form,
- History and Physical,
- Labs,
- Copy of the patient's Insurance Card

Thank you for your assistance and thank you for trusting Covenant Health Sleep Centers.

Physician's Signature

____/____/____
Date

Sleep Disorders Center Use Only

Office Contact:	Study Precert:
Insurance Contact:	

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