SLEEPWERX

YOUR SLEEP AND WELLNESS CENTER

PATIENT REFERRAL FORM

SleepWerx LLC.

3514 N. Power Rd. Ste. 127

Mesa, AZ. 85215

Phone: 480.571.8460

Fax: 480.571.8461

Patient Name: _____ Date of Birth: ___/___/_____ Male: __ Female: __

Address: _____ Phone: ___/___/_____

_____ Initial Consultation: Comprehensive evaluation of patient with diagnostic sleep study.

Suspicious symptoms suggestive of obstructive sleep apnea include:

Observed apneas	Dry mouth upon wakening
Loud Snoring	Bruxism/Grinding
Frequent awakening	Excessive daytime sleepiness
Morning headaches	Chronic fatigue
Drowsy driving	Prior diagnosis of OSA
Falling asleep at inappropriate times	Choking/gasping while asleep
Mallampati I II III IV	Other:_____

_____ Re-Evaluation Consultation. Please test patient: with/without oral appliance.

Dentist's Signature: _____ Print Name: _____

Address: _____ Date: _____

Phone: _____ Fax: _____

Special instructions: _____

Please fax referral form, patient demographics, copy of patient's insurance card and pertinent clinical notes.

THANK YOU FOR REFERRING YOUR PATIENT TO SLEEPWERX!