CULLMAN REGIONAL | Medical Group

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Phone: 256-903-0300 **Fax:** 256-801-7893

SLEEP MEDICINE CONSULT REFERRAL

Patient name _____

DOB _____ Phone # _____ Cell # _____

Address _____

Insurance Carrier _____ Policy # _____

1. Please describe the patient's chief complain and include onset and frequency.

_____

_____

_____

_____

2. What is the key question you would like us to answer?

_____

_____

_____

To expedite appointment scheduling, please provide the following by fax **256-801-7893**:

- ☐ This completed form
- ☐ Medical Records related to chief complaint
- ☐ Prior neurology records including EEG, EMG, CT or MRI results
- ☐ Prior Authorization, or if not applicable, a copy of insurance card
- ☐ Most recent office note
- ☐ Pertinent lab/procedure results

REFFERING PROVIDER

Physician _____ Address/Location _____

Phone _____ Fax _____

Provider Signature _____ Today's date _____

Appt. Date and Time _____

Patient notified on _____

Physician offices will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures

Please include insurance referral, if required.

Phone 256-903-0300 · Fax 256-801-7893