

# Advanced Respiratory & Sleep Medicine

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Pulmonary/Critical Care/Sleep Medicine/Internal Medicine

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## Referral Form

Patient Information:					
Patient Name:				Date:	
Address:			City:	State:	Zip:
Tel: H:	W:	C:	email:		
DOB:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Urgency level: <input type="checkbox"/> Low <input type="checkbox"/> Mod <input type="checkbox"/> High			
Primary Insurance:					

Referring For:		
<input type="checkbox"/> PULMONARY CONSULT	<input type="checkbox"/> SLEEP CONSULT	<input type="checkbox"/> INTERNAL MEDICINE CONSULT
<input type="checkbox"/> CRITICAL CARE SERVICES	<input type="checkbox"/> POST-HOSPITAL OFFICE VISIT	<input type="checkbox"/> HOSPITALIST SERVICES
<input type="checkbox"/> PULMONARY FUNCTION TEST	<input type="checkbox"/> SPIROMETRY	<input type="checkbox"/> 6-MINUTE WALK TEST
<input type="checkbox"/> BRONCHODILATOR DEMO	<input type="checkbox"/> PRE-OP PULMONARY EVALUATION	<input type="checkbox"/> COPD/ASTHMA MANAGEMENT
<input type="checkbox"/> DIAGNOSTIC POLYSOMNOGRAM	<input type="checkbox"/> SPLIT-NIGHT POLYSOMNOGRAM	<input type="checkbox"/> TITRATION STUDY
<input type="checkbox"/> MULTIPLE SLEEP LATENCY TEST	<input type="checkbox"/> MAINT. OF WAKEFULNESS TEST	<input type="checkbox"/> PORTABLE HOME SLEEP TEST
<input type="checkbox"/> OVERNIGHT OXIMETRY	<input type="checkbox"/> CPAP EVALUATION	<input type="checkbox"/> CPAP OR BIPAP SERVICE/SUPPLIES
<input type="checkbox"/> DENTAL DEVICE EVALUATION	<input type="checkbox"/> APNEA SURGERY EVALUATION	<input type="checkbox"/> PROVENT DEVICE EVALUATION
<input type="checkbox"/> HOME OXYGEN EVALUATION	<input type="checkbox"/> CPAP MASK FITTING/EDUCATION	<input type="checkbox"/> OTHER:

Patient Clinical Information:					
<input type="checkbox"/> COUGH	<input type="checkbox"/> DYSPNEA	<input type="checkbox"/> LUNG MASS	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> COPD
<input type="checkbox"/> ABNORMAL XRAY OR CT	<input type="checkbox"/> INTERSTITIAL LUNG DISEASE	<input type="checkbox"/> PULMONARY HYPERTENSION			
<input type="checkbox"/> OTHER. DESCRIBE:					

Referring Provider Information:			
Provider Name:		Tel:	Fax:
Address:		City:	State: Zip:
Specialty:		Signature:	