

VCUHS Center for Sleep Medicine

2529 Professional Road

Richmond, VA 23235

Phone-(804) 323-2255 Fax-(804) 323-2262

Intake and Referral Form

Date: _____ Requesting Physician: _____
Physician Office Phone: _____ Fax: _____ (Both Required)
Patient Name or Label: _____ DOB: _____
Address: _____ Height: _____
Weight: _____
Phone: _____ BMI: _____
Work: _____ Cell: _____

Insurance Information

Primary Insurance: _____
Expiration: _____

PLEASE INCLUDE BRIEF MEDICAL HISTORY AND RECENT OFFICE NOTES

Reason For Referral/Consultation

_____ Witnessed Apnea _____ Daytime Fatigue _____ Weight Gain
_____ Snoring _____ Hypersomnolence _____ Restless Sleep
_____ Morning Headache _____ Insomnia _____ Other

Describe Other: _____

_____ Epworth Sleepiness Score (If Available)

Medical History

_____ Apnea _____ HTN _____ Depression _____ Blood Disorder
_____ CHF _____ DM _____ GERD _____ Cardiac (Specify)
_____ COPD _____ Neuropathy _____ Thyroid _____ Other

Describe Other: _____

Physician Signature: _____

Your Referral is important to us. In an effort to better serve you, please note:

Community Referrals will receive an appointment confirmation via fax.
VCUHS Clinics and Physicians please refer to IDX for the appointment date.