



# SLEEP REFERRAL CHECKLIST

**SLEEP REFERRAL CHECKLIST**

DATE: \_\_\_\_\_

TO:  REM Sleep Diagnostics  
 855 Bordeaux Way, #220  
 Napa, CA 94558  
 707-252-8400  
 707-252-4700 fax

REM Sleep Diagnostics  
 1050 Northgate Drive, #250  
 San Rafael, CA 95903  
 415-507-1860  
 415-507-1833 fax

REM Sleep Diagnostics  
 750 Mason Street, #205  
 Vacaville, CA 95688  
 707-469-8400  
 707-469-8469 fax

**FROM:**

THE OFFICE OF: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

RE: **REFERRAL FOR SLEEP CONSULTATION**

PATIENT: \_\_\_\_\_

DOB: \_\_\_\_\_ PHONE #: \_\_\_\_\_

**THANK YOU IN ADVANCE FOR INCLUDING THE FOLLOWING INFORMATION:**

- History and Physical** — describing the patient’s most recent history/physical and reason for referral.
- Current patient demographic information and a copy of insurance card.**

We appreciate your referral; we will communicate with you on the progress of your patient, as well as send any reports from testing and/or follow-up visits.

Thank you for trusting your patients to REM Sleep Diagnostics!

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