SLEEP CENTER OF KENTUCKIANA

7926 Preston Hwy., Ste.200
Louisville, KY 40219
Tel: (502) 964-2440
Fax: (866) 845-0491
www.KentuckySleep.com

PULMONARY AND SLEEP MEDICINE

Referral Form

Please fill out the information below and fax it to **(866) 845-0491**.

AASM 2022 ACCREDITED Facility Member

Today's Date: _____ Referring Physician Signature: _____

Type of referral: ☐ Sleep Test ☐ Pulmonary ☐ Medical Equipment

PATIENTINFORMATION

Patient Name:	**Date of Birth:**	**Social Security #**	
Home Phone:	**Cell Phone:**	**Gender:** ☐ **Male** ☐ **Female**	
Patient Address:	**City:**	**State**	**Zip Code**

Chief Complaint(s) of patient ***(check all that apply):***

- ❑ Excessive Daytime Sleepiness
- ❑ Snoring/Sleep Apnea
- ❑ Insomnia
- ❑ Possible Narcolepsy
- ❑ Restless Legs Syndrome
- ❑ Sleepwalking/talking/eating
- ❑ Other (please specify): _____
- ❑ Circadian Rhythm Disorder
- ❑ Night Terrors
- ❑ Sleepwalking/talking/eating
- ❑ COPD
- ❑ Asthma
- ❑ Lung Cancer
- ❑ Lung Infection (Pneumonia)
- ❑ Blocked Lung Artery (Pulmonary Embolus)
- ❑ Swelling & Inflammation (Bronchitis)
- ❑ Collapse of part or all lung
- ❑ Build up of fluids in lungs (Pulmonary Edema)

INSURANCE INFORMATION

You can either fill out the information below or fax a legible copy of the insurance card along with this form.

Name of Insurance Company: _____

Member ID number: _____

WE ACCEPT ALL INSURANCE

For Sleep Center use only

Appointment Confirmation:

Date: _____ Time: _____

Physician Name: _____

PASSPORT ID 50019439