



Referral Form

Affiliated Board Certified Sleep Physicians:

Kin Min Yuen, MD, Medical Director
 June Seliber-Klein, MD
 Victoria Zvonkina, MD
 Stephen Brooks, MD

Please fax insurance information
 and relevant medical notes to



1-866-44-APNEA
(1-866-442-7632)

Phone: 866-88-SNORE (866-887-6673)

Patient Name			Date of Birth	
Primary Phone		Alternate Phone		
Address				
City / State			Zip	
Email Address				

Patient Symptoms/Complaints

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Night Terrors | <input type="checkbox"/> Weight Gain/Obesity |
| <input type="checkbox"/> Witnessed Apnea | <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Bruxism | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Restless Legs | <input type="checkbox"/> Nocturia/Enuresis | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Morning Headaches | <input type="checkbox"/> Arrhythmia |

Requested Services

SLEEP CONSULTATION with a Bay Sleep Clinic Physician

SLEEP TESTING:

- POLYSOMNOGRAPHY (PSG): Diagnostic
- CPAP/Bi-Level TITRATION STUDY
- SPLIT-NIGHT STUDY (Minimum 2 hours PSG. Titration initiated only if approximate AHI > 40)
- MSLT MWT
- HOME SLEEP STUDY, UNATTENDED: Diagnostic

Has the patient had a previous sleep study? Yes No If yes, where? _____ When? _____

Referring Doctor

Name	UPIN #	NPI #	
Address	City	ST	Zip
Phone	Fax		
Signature:		Date:	

I attest that the service(s) prescribed are medically necessary and adhere to the standards of medical practice and treatment of this patient's condition.

~~~~~ **California Locations** ~~~~~

**Gilroy | Los Gatos | Mountain View | Oakland | Pleasanton | Salinas**  
**San Francisco | San Jose | Santa Cruz | South San Francisco | Walnut Creek**

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