



South Texas Sleep Disorder Clinic

Fax Referral Form

Please complete this form and fax to the South Texas Sleep location listed below.
Our staff of Sleep Professionals will verify insurance, contact the patient and notify you
of the scheduled test date.

Date: _____

Patient Name: _____

Patient Address: _____

Patient Phone: Primary: _____

Cell or work: _____

Birthday: _____

S.S. # : _____

Diagnosis: _____

Primary Insurance: _____ I.D. # _____

Ordering Physician: _____ UPIN # _____

Address: _____

Phone: _____ FAX: _____

Order: Diagnostic Sleep Study _____

Titration Sleep Study _____

Initiate CPAP/ BIPAP Therapy to treat _____

Physician signature: _____

FAX to 1-866-407-8732