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: _____

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_____ 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.