6500 Busch Blvd Suite 104
Columbus, OH 43229

(o) 614-396-8286
(f) 855-858-4924

OHIO SLEEP TREATMENT LLC

Monday 8:30a - 5:30p
Tuesday 8:30a - 7:30p
Wednesday 8:30a - 4:00p
Thursday 7:30a - 5:30p
Friday 8:30a - 12:30p
Lunch from 12p-1p

Referral for evaluation for Obstructive Sleep Apnea (E0486)(G47.33)

Referring Provider: _____ Provider Phone Number: _____

Patient Name: _____ DOB: _____

Patient Address: _____

Patient Telephone #: _____

The above referenced patient is being referred as a result of the following:

Patient reports

- ☐ Wake up feeling unrested
- ☐ Tired throughout the day
- ☐ History of snoring, choking or gasping
- ☐ Clenching, grinding at night
- ☐ CPAP non-compliant, prefer alternative

Other _____

Clinical indications

- ☐ Enlarged, scalloped tongue
- ☐ Enamel wear
- ☐ Pharyngeal crowding
- ☐ Large neck
- ☐ Mallampatti score of 3 or 4

Other _____

Additional notes: _____

_____

Patient's Chief Complaint: _____

Signature of Referring Provider: _____ Date: _____