Lakeside Sleep Care Referral Form

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Referring Clinician Information

Referring Clinician/Practice: _____

Patient Information

Patient Name: _____

Date of Birth: _____

Phone and/or email: _____

Reason for Referral (select all that apply)

☐ Insomnia (evaluation and/or Cognitive Behavioral Therapy for Insomnia)

☐ Suspected Obstructive Sleep Apnea Evaluation (including Home Sleep Apnea Testing)

☐ Obstructive Sleep Apnea Treatment/ Follow-up

☐ Suspected Restless Legs Syndrome

☐ Circadian Rhythm / Sleep Timing Concerns

☐ Other: _____

Brief Clinical Summary / Notes

Please briefly describe the reason for referral and any relevant history.

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