



Dream Care Sleep & Wellness Center
1346 Dowell Springs Blvd • Knoxville, TN 37909
Phone: 865-234-4311 • Fax: 865-351-0035
www.dreamcaresleep.com

Sleep Medicine Referral Form

Fax completed form to 865-351-0035 or email securely to: scheduling@dreamcaresleep.com

Please Include (if available):

- | | |
|--|--|
| <input type="checkbox"/> Physician order | <input type="checkbox"/> Insurance card (front & back) |
| <input type="checkbox"/> Most recent H&P / Office note | <input type="checkbox"/> Prior sleep studies |

Patient Information:

Patient Name: _____ DOB: ____ / ____ / ____ Sex: M F
Insurance: _____ Name on Insurance card: _____
Subscriber / Member ID: _____ Group #: _____
Phone #: _____ Email: _____
Address: _____

Referring Provider / Office Information:

Provider name: _____ Practice / Specialty: _____
NPI #: _____ Phone #: _____
Fax #: _____
Office Contact person: _____ Email: _____

Reason for Referral (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Sleep apnea / Snoring | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Excessive Daytime Sleepiness / Fatigue | <input type="checkbox"/> Narcolepsy / hypersomnia |
| <input type="checkbox"/> Restless leg syndrome | <input type="checkbox"/> CPAP issues / intolerance |
| <input type="checkbox"/> Dental oral appliance evaluation | <input type="checkbox"/> Inspire evaluation |
| <input type="checkbox"/> Home sleep testing request | |
| <input type="checkbox"/> Other Clinical info : _____ | |
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