Vanguard Sleep Disorders Center LLC
17B Marshellen Drive
Beaufort, SC 29902
Phone: 843-962-0714
Fax: 843-941-3720

Sleep Medicine Referral / Order Form

*****Please fax completed form along with most recent office visit note including history and physical, medication list and any other pertinent information to: 843-941-3720*****

Patient Information

Patient Name: _____ Date Of Birth: _____

Phone #: _____ Alternate Phone #: _____

Address: _____ City: _____State:_____ ZIP: _____

Height: _____ Weight: _____ BMI: _____ Neck Circumference: _____ Gender: ◉ Male ○ Female

Patient Insurance Information

Policy Holder Name: _____Date Of Birth_____

Primary Insurance Company Name: _____ Policy #: _____

Group #: _____ Policy Type: _____

**Does the patient have secondary insurance? ○ Yes ○ No — If yes, please attach both primary and secondary insurance cards.

Requested Procedure(s)

☐ Baseline Polysomngram (In Lab) ☐ Home Sleep Study (Level III) ☐ CPAP/BiPAP Titration Study

☐ Multiple Sleep Latency Test (MSLT) ☐ Maintenance of Wakefulness Test ☐ (MWT)

☐ Sleep Consultation ☐ Other: _____

___ If an in lab PSG is requested and insurance will not approve it but will allow a home sleep study, may a home sleep study be scheduled? ☐ Yes ☐ No

Sleep Symptoms and CoMorbid Conditions

☐ Snoring ☐ Witnessed Apnea ☐ Choking/Gasping During Sleep ☐ Frequent Awakenings

☐ Morning Headaches ☐ Restless Limbs ☐ Sleep Talking ☐ Sleep Walking ☐ Sleep Paralysis ☐ Insomnia

☐ Excessive Daytime Sleepiness ☐ Fatigue ☐ Night Terrors ☐ Hallucinations Upon Falling Asleep or Awakening

☐ History of Heart Disease ☐ History of Stroke ☐ COPD ☐ Hypertension ☐ Depression ☐ Neuromuscular Disease

☐ Diabetes ☐ Cognitive Deterioration ☐ Other:_____

Referring Physician Information

Referring Physician Name: _____ Referring Physician NPI: _____

Phone #:_____ Fax #: _____ Office Contact: _____

Office Address: _____

Referring Physician Signature: _____ Date: _____