39 New London Turnpike, Suite 325
Glastonbury, CT 06033
Phone: 860.819.4689
Fax: 860.398.6436
Email: info@logzzz.com
www.logzzz.com

Physician Referral Form

Request for In-home Sleep Study

Please print legibly

Patient's Last Name		Patient's First Name		Patient's Middle Initial
Date of Birth (mm/dd/yyyy)	Weight (lbs.)	Height (in.)	Neck Size (in.)	Gender M/F
Age	Best Contact Phone Number		Alternate Phone Number	
Insurance			Policy Number	
Prior Authorization			Date Referred	
Ordering Physician			Physician's Telephone Number	

Please indicate if your reason for the referral is any of the following:

Snoring	_____	Excessive daytime sleepiness	_____
Insomnia	_____	Morning Headaches	_____
Witnessed Pauses in breathing	_____	Known OSA	_____
Awakening – chocking or gasping	_____	On C-Pap Therapy	_____
Other:			

Patient's Medications:

☐ **Coordination of treatment with DME company for PAP therapy**

Referring Physician's Signature: _____ Date: _____