Phone: 803-795-5571
Fax: 864-752-6495
Email: truesleepsc@gmail.com

Patient Information

Patient Name:_____ DOB:____/____/_____

Height:_____ Weight:_____

Parent Name (if applicable): _____

Best Contact Phone:_____ Email:_____ ☐M ☐F

Address:_____ City:_____ St:____

Zip:_____

Referring Entity Information

Referring Provider:_____ Office Contact: _____

Address:_____ City:_____ St:_____ Zip:_____

Phone:_____ Fax:_____

Pediatric complaints and/or symptoms

☐ Snoring
☐ Bed Wetting
☐ Nocturnal Choking/Gasping
☐ Delayed/Reduced Growth/Maturity
☐ Daytime Sleepiness
☐ Unexplained aggression
☐ Sleep Walking/Talking
☐ Headaches
☐ Sleep Paralysis
☐ ADHD symptoms

Physician Order

☐ **Home sleep test pediatric ($200)**
☐ **Home sleep test adult ($250)**
☐ **Home sleep test x2 uses ($400)**

I certify: The information provided is true, accurate and documented in the patient's clinical notes.

Signature:_____ Date:_____

Typed name serves as signature for physicians, patients, or parents

We are very thankful for your referral!
Please ask the patient/parent to complete the consent form.