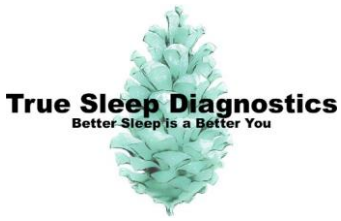

Phone: 803-795-5571
Fax: 864-752-6495
Email: truesleepsc@gmail.com

Patient Information

Patient Name:_____ DOB:____/____/_____

Height:_____ Weight:_____

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

Adult complaints and/or symptoms

- ☐ Loud Snoring/Disrupted Sleep
- ☐ Witnessed Apnea
- ☐ Nocturnal Choking/Gasping
- ☐ Daytime Hypersomnolence
- ☐ Non-Refreshing Sleep
- ☐ Drowsy Driving
- ☐ Morning Headaches
- ☐ Sleep Paralysis
- ☐ Leg Jerks or Restless Legs

Physician Order

- ☐ **Home sleep test pediatric ($300)**
- ☐ **Home sleep test adult ($350)**
- ☐ **Home sleep test x2 uses ($500)**

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

Provider Signature:_____ Date:_____

Typed name serves as signature for physician, patients, or parents.

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