



# Woodinville Sleep Improvement Center

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## Services Requested

Sleep Consultation

Overnight Sleep Study (PSG)

CPAP Supplies

## Referral Information

Patient Name \_\_\_\_\_

DOB \_\_\_\_\_

Phone \_\_\_\_\_

Primary Insurance \_\_\_\_\_

Subscriber # \_\_\_\_\_

Referring Physician \_\_\_\_\_

Phone \_\_\_\_\_

Specify Additional Concerns \_\_\_\_\_  
\_\_\_\_\_

## Sleep Questionnaire

Snoring or witnessed apneas

Daytime sleepiness

Falling asleep at the wheel

Consumes daily energy drinks and/or caffeine

Trouble initiating or maintaining sleep

High cholesterol, diabetes, or hypertension

Ten or more pounds overweight

Referring Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

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**Please fax completed form to: (425) 286-6257**

Thank you for choosing Woodinville Sleep Improvement Center!