

**TEXAS PULMONARY & CRITICAL  
CARE CONSULTANTS, P.A.**

*Pulmonary and Critical Care Specialists*

**SLEEP CONSULTANTS, INC.**

1521 Cooper Street, Fort Worth, TX 76104  
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***Comprehensive Care of Sleep Disorders: Diagnosis, Treatment, Follow-up, Education, Research***

**PATIENT REFERRAL**

Date: \_\_\_\_\_

Prior sleep testing? – YES / NO If yes, when and where: \_\_\_\_\_

**Sleep-related diagnosis:** \_\_\_\_\_

**Patient Information:**

Last Name: \_\_\_\_\_ First Name/Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Sex: M F Marital Status: M S D W

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Specialty: \_\_\_\_\_ Caller: \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ NPI: \_\_\_\_\_

PCP Phone: \_\_\_\_\_ PCP Fax: \_\_\_\_\_

**AN APPOINTMENT WILL NOT BE MADE WITHOUT A COPY OF THE PATIENT'S INSURANCE CARD - PLEASE ATTACH!  
WE ALSO NEED MOST RECENT PHYSICAL EXAMINATION AND PERTINENT MEDICAL ASSESSMENT.**

**PRIMARY INSURANCE POLICY:**

Insurance Co. \_\_\_\_\_ ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insured's Birth Date \_\_\_\_\_ SSN \_\_\_\_\_ Sex: M F

Claims Mailing Address \_\_\_\_\_

Phone No. \_\_\_\_\_

**SECONDARY INSURANCE POLICY:**

Insurance Co. \_\_\_\_\_ ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insured's Birth Date \_\_\_\_\_ SSN \_\_\_\_\_ Sex: M F

Claims Mailing Address \_\_\_\_\_

Phone No. \_\_\_\_\_

Appointment Date: \_\_\_\_\_ With: \_\_\_\_\_ Scheduled by: \_\_\_\_\_ (Initials)

*Please evaluate and/or perform studies on the above patient.*

\_\_\_\_\_  
*Signature of Ordering Physician*

\_\_\_\_\_  
*Date*