betternight

Send to our HIPAA compliant portal at awaken2sleep.com/tele-med

AWAKEN 2 SLEEP

Dental Sleep Medicine Referral Form

Section 1: Patient Information (required)

Patient Name:

Referring Dentist:

Address, City, State, Zip:

Address, City, State, Zip:

Date of Birth:

Phone:

Home Phone:

Fax:

Cell Phone:

Patient Email:

Work Phone:

National Provider Identifier:

Section 2: Diagnostic Service

☐ **Online consult to assess need for a Sleep Apnea Test.**

Notes:

Practitioner Signature:

Date: