REFERRAL FORM

DATE _____

Hyong W. Shim, MD – Medical Director, AASM Diplomat
1395 Commercial Street SE Salem, OR 97302
Ph: 503-990-7187 Fax: 503-990-7437
salemsleepmedicine.com

PATIENT INFORMATION:

_____ _____ _____ _____ _____
LAST NAME FIRST NAME M.I. SEX DATE OF BIRTH

_____ _____
REFERRING PHYSICIAN PRIMARY CARE PHYSICIAN

_____ _____
CHIEF COMPLAINT DIAGNOSIS CODE(S)

_____ _____ _____
PRIMARY INSURANCE SUBSCRIBER I.D. GROUP NUMBER

_____ _____ _____
SECONDARY INSURANCE SUBSCRIBER I.D. GROUP NUMBER

IF PRIOR AUTHORIZATION IS REQUIRED BY PATIENT'S INSURANCE, PLEASE OBTAIN *PRIOR* TO SENDING REFERRAL.

IS PRIOR AUTHORIZATION REQUIRED? **Y / N** IF YES, AUTHORIZATION NUMBER _____

SLEEP STUDIES MUST BE ORDERED BY DR. SHIM. IS THIS REFERRAL FOR (CIRCLE ONE):

SLEEP DISORDER EVALUATION AND TREATMENT OVERNIGHT PULSE OXIMETRY

_____ _____
REFERRING PHYSICIAN SIGNATURE DATE

PLEASE FAX US A REFERRAL FORM ALONG WITH CHART NOTES AND PATIENT DEMOGRAPHICS TO THE NUMBER AT THE TOP OF THE FORM AND WE WILL CONTACT THE PATIENT TO SCHEDULE AN APPOINTMENT.
THANK YOU FOR CHOOSING SALEM SLEEP MEDICINE.