Sovewell

Provider Referral Form

Phone: 740-245-6291
Fax: 1-800-870-5485
www.sovewell.com

Referral Steps

Fax this completed referral form to 1-800-870-5485, along with:

- Any previous sleep study reports, if completed
- Most recent provider progress note
- Patient insurance card

Patient Information

Name: _____ Date of birth: _____

Phone: _____ Email: _____

Reason for Referral (check all that apply)

- ☐ New patient with suspected OSA who needs a visit and home sleep apnea test (HSAT)
- ☐ DOT / FAA compliance visit
- ☐ Patient has a diagnosis of OSA, but needs to start therapy
- ☐ Established OSA diagnosis — needs compliance check / CPAP or BiPAP supplies
- ☐ Insomnia — referral for Brief Behavioral Treatment of Insomnia (BBT-I)
- ☐ Other / Comments: _____

_____

Referring Provider Information

Provider name: _____

Practice name: _____

Phone: _____ Fax: _____