NorthStar
SLEEP DISORDERS CENTER

Please fax to: (360) 676-6636

Patient Name: _____ **Phone:** _____

Primary Insurance: _____ **Referral Date:** _____

Zachary Webb, M.D.

- ❑ Consultation; sleep study with followup if indicated
- ❑ Sleep study and followup consultation only

Indication for referral

- ❑ Obstructive Sleep Apnea – 327.23
- ❑ Restless Leg Syndrome – 333.99 / 780.58
- ❑ Narcolepsy – 347.00
- ❑ Parasomnia – 307.47
- ❑ Insomnia – 780.52
- ❑ CPAP/BIPAP Assessment
- ❑ Hypersomnia - 780.54
- ❑ Circadian Rhythm Disorder - 780.55
- ❑ Other _____

PLEASE INCLUDE:

- Patient fact sheet or demographics
- Any copies of relevant office notes or history and physical
- Any required managed care referral

Thank you for your kind referral

Provider's Signature: _____

Provider's Name: _____ **c.c. Report To:** _____

Telephone: (_____)_____ **Fax:** (_____)_____

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