FOUNDATIONS
SLEEP APNEA & AIRWAY

Referral for Sleep Consultation
Dr. Lauren Hubbard DDS
952-472-7738
Email referral: sleep@foundationspsa.com

Patient information Today's Date: _____

Patient Name: _____ DOB: _____ Gender: _____

Cell phone number: _____ Home phone number: _____

Medical Insurance card: Please attach a copy front/back

Reason for referral Please check all that apply:

- ☐ Sleep Apnea symptoms (snoring, gasping, choking)
- ☐ Excessive daytime sleepiness
- ☐ Insomnia
- ☐ Sleep walking/talking
- ☐ CPAP not compliant or non-tolerant
- ☐ Obesity Snoring
- ☐ Stroke
- ☐ Morning headaches
- ☐ Other

Date of last panoramic x-ray: _____

Date of last cephalometric x-ray: _____

Please forward x-rays or any relevant patient information to **sleep@foundationspsa.com**

Comments/Special instructions:

Clinic information

Referring Doctor: _____

Office phone number: _____

Email address: _____