The Sleep Center
515 SW Horne, Suite 200 Topeka, KS 66606
(785) 234-5480 Fax (785) 234-3124

Scheduling Check List

Patient Name:_________________________________ Date of Birth:_________________

Referring Physician:____________________________ Date of Referral ________________

All items must be received by the Sleep Center, prior to patient testing:

Patient Demographic information / face sheet ___________

Copy of patient insurance card (both sides) ___________

Copy of photo I.D. ___________

Initialed and signed release of information ___________

Complete, signed physician order sheet ___________

Signed history & Physical or office notes reflecting the need for sleep testing ___________

Referral or pre-certification if necessary ___________

Sent by Fax_______ USPS ________ Date:_______________ Initials:_____________________________

To schedule testing: 785-234-5480

Person scheduling: ________________________________ Date: _______________________________

Sleep services scheduled: ____

Person notifying the patient: ________________________ Date/Time Notified:____________________

Sleep questionnaire and diary provided _________________