telemedora
Bringing quality sleep care home

TELEMEDORA REFERRAL FORM

Referring Clinician Information

Name: _____
(First Name) (Last Name) (Title)

Practice Name: _____

Clinician NPI: _____ Clinician Specialty: _____

Address: _____

_____

Phone: _____ Fax: _____
(Area code) 000-0000 (Area code) 000-0000

Patient Information

Name: _____
(First Name) (Middle Name) (Last Name)

Address: _____

_____

Date of Birth: _____ ☐ Male ☐ Female
(MM/DD/YYYY)

Phone: _____ Email: _____
(Area code) 000-0000

Payment Information: ☐ Commercial Insurance ☐ Medicare ☐ Self-Pay

Would the patient need interpreter? ☐ No ☐ Yes. Which language? _____

Reason for Referral: ☐ Sleep Apnea ☐ Determine Efficacy of Oral Appliance
☐ Snoring ☐ Other: _____

Items To Be Faxed To 650-309-1678

☐ Patient's Driver's License ☐ Insurance Card ☐ Referral Form ☐ Office Note

650-687-7368 650-309-1678 info@telemedora.com
www.telemedora.com