POMONA VALLEY HOSPITAL
MEDICAL CENTER

SLEEP DISORDERS CENTER

PATIENT INFORMATION:			
Last, First:	_____,_____	**Home Phone:**	(_____)_____-_____
Address:	_____	**Additional Phone:**	(_____)_____-_____
City:	_____	**SS#:**	_____-_____-_____
State:Zip	_____	**Date of Birth:**	_____
		Gender:	_____
Insurance Carrier: _____			

☐ **Consultation with Sleep Consultant**

(Must check a physician below)

Sleep Panel Members:

- ☐ Heather Davis, M.D., Sleep Consultant/Pulmonary
- ☐ *Fares Elghazi, M.D., ABIM Diplomate in Sleep Med.
- ☐ *Nadir Eltahir, M.D. ABIM Diplomate in Sleep Med.
- ☐ Carrie Knoll, M.D. ABIM Diplomate in Pediatric Sleep Med.
- ☐ *Robert C. Jones, M.D., ABIM Diplomate in Sleep Med
- ☐ Gary Demerjian D.O.

*American Board Certified/Eligible Sleep Specialist

- ☐ *Dennis H. Nicholson, M.D., ABIM Diplomate in Sleep Med
- ☐ *Gurbinder Sadana, M.D., ABIM Eligible Sleep Specialist
- ☐ Rohinder Sandhu, M.D., Sleep Consultant/Pulmonary
- ☐ Baburaj Thankappan M.D. Sleep Consultant/Neurology
- ☐ Surjit Kahlon, M.D. Sleep Consultant/Ped. Neurology
- ☐ Rakesh Sinha, M.D. Sleep Consultant/Pulmonary

*American Board Certified/Eligible Sleep Specialist

- ☐ Daniel Skenderian, PhD; Sleep Psychologist Consultation

Sleep Study Checklist: Please fax all of the information listed below, along with this referral form, and we will contact the patient to set up an appointment for a consultation.

- ☐ **Copy of insurance card (front & back)**
- ☐ **Copy of authorization for CPT code: 99244**
- ☐ **Medications and Allergies list**
- ☐ **Sleep history and physical consult**

REFERRING PHYSICIAN INFORMATION:			
Name:	_____	**Contact Name:**	_____
Address:	_____	**Office Phone:**	(_____) _____-_____
	_____	**Office Fax:**	(_____) _____-_____
City:	_____	**UPIN:**	_____
State:	_____ **Zip:** _____		

M.D. /D.O. / PhD. Signature: _____ **Date:** _____

Phone 909-865-9152 Fax 909-630-7947

1601 N. Monte Vista Ave #270

Claremont, CA 91711

* Thank you for your referral *