

PATIENT REFERRAL TO THE COLUMBUS COMMUNITY HEALTH REGIONAL  
SLEEP DISORDERS CENTER

Robert W. Clark, M.D., Medical Director  
1430 South High Street, Columbus OH 43207 -- Tel: (614) 443-7800  
E-mail address: flamenco@netexp.net

Please return completed form by fax, surface mail or e-mail with copies  
of any relevant medical records if they might help us help your  
patient).

PATIENT INFORMATION:

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Address:

Street \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone--home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Work: (\_\_\_\_) \_\_\_\_\_

Suspected diagnoses for which patient is being referred:

\_\_\_\_\_  
\_\_\_\_\_

Type of insurance:

\_\_\_\_\_

Comments:

\_\_\_\_\_

REFERRING DOCTOR (OR USE ADDRESS STAMP):

Dr.

\_\_\_\_\_

Address:

Street \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_

Thank you for the referral! We will be in contact with you promptly  
after your patient's initial visit.