



KETTERING/SYCAMORE  
SLEEP DISORDERS CENTERS  
KETTERING HEALTH NETWORK™

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## KETTERING/SYCAMORE SLEEP DISORDERS CENTERS Fax Referral Form

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We are happy to contact the patient and schedule a consultation upon receipt of this fax.  
Please complete this form and fax directly to the center at 937-395-8821.

Date: \_\_\_\_\_

Facility Preference:     Kettering     Sycamore     First Available

Referring Physician's Name: \_\_\_\_\_

Referring Physician's Office Phone Number: \_\_\_\_\_

Patient's Full Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Patient's Phone Number: (Home)\_\_\_\_\_ (Work)\_\_\_\_\_

Patient's Insurance: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

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This fax line is used to send and receive patient private health information; it meets both federal and state patient privacy guidelines and is a secure line.  
This message and the accompanying documents or attachments may contain information which is privileged and/or confidential. If you are not the intended recipient, you may not review, discuss, disclose, copy or distribute the contents of this message.  
If you have received this information in error, please immediately contact the physician's office whose number is listed on the message and destroy all evidence of this correspondence.

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