



Sleep Solutions Center

Sleep Disorder Evaluation Order Form

Phone # 541-744-6000 option 2. Fax # 541-744-6053

Appointment Date: _____ Time: _____

Patient Name: _____

DOB: _____ SSN: _____

Diagnosis _____

ICD-9 Code _____

Physician Signature: _____

Please fax overnight oximetry results if available, and recent History and physical or chart notes with this order form.

Our scheduling center will contact your patient to schedule an appointment.

Thank you



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