SLEEPTEST.COM

Inspire Referral Form

iMednet Study ID -

Patient Information

Patient Name ____________________________ Gender _____ DOB ___ / ___ /___

Address ________________________________ City ______________________ State _______ Zip ________________

Cell Phone _____________________________________ Email ____

Height ___ ' ___ " Weight _____ lbs BMI _______

Patient Confirmation Call Schedule your patient's call with SleepTest.com at: www.SleepTest.com/Calendar

HST Interval: ***3-Month*** ***6-Month***

Referring Clinician Information

NPI # _____________________ License #________________________

Practice Name _____________________________________ Doctor Name___________________________________

By signing this form, I am referring the patient listed above for a home sleep test to determine efficacy of the Inspire implant therapy.

Doctor Signature ____ **Date** ______/______/______

Instructions Upload this form into the portal at **www.SleepTest.com**

Need Help? Call 630-845-4384