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OHIO SLEEP MEDICINE INSTITUTE
CENTER OF SLEEP MEDICINE EXCELLENCE™

MARKUS H. SCHMIDT, M.D., Ph.D.
President and Director of Research
Diplomate-American Board of Sleep Medicine

ASIM ROY, M.D.
Medical Director
Diplomate-ABPN Sleep Medicine

SHARIS C. SHABANDARI, C.N.P.
Clinical Nurse Practitioner

DEEPA PATEL, C.N.P.
Clinical Nurse Practitioner

MARY HURLEY, C.N.P.
Clinical Nurse Practitioner

# Referral Form

## Fax to 888.491.5348 **with insurance card**

Patient Name: _____ DOB: _____

Patient Telephone (H): _____ (W): _____ (Cell): _____

Primary Insurance: _____Member ID_____ Group#_____

Secondary Insurance: _____ Member ID_____ Group#_____

Referring Physician (print name): _____

Physician Address: _____

Physician Tel: _____ Fax: _____

Reason(s) for referral

- ☐ Obstructive Sleep Apnea
- ☐ Restless Legs Syndrome
- ☐ Narcolepsy
- ☐ Insomnia
- ☐ Other_____

Physician Signature: _____ Date: _____

Please select preferred office location for referral:

☐ Dublin Office
4975 Bradenton Ave.
(Off of I-270/Tuttle Crossing and Frantz Road.)

☐ New Albany Office
7277 Smith's Mill Rd.
(Take Johnstown Road or Rt 62 exit just north of Rt 161)

☐ Either office or first available