



**McKenzie-Willamette**

MEDICAL CENTER

*extraordinary care*

**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 appointment.

Thank you