Goshen Physicians
SLEEP & ALLERGY MEDICINE

2417 S Berkshire Drive
Goshen, IN 46526

Phone: (574)534-9911
Fax: (574) 534-6915

Sleep & Allergy New Patient Referral Form

Sultan Niazi, MD
Deborah Risa, NP-C
Katherine O'Toole, NP-C
Stephanie Cross, MSN, APRN, AGNP-C

Name: ______________________ **Sex:** ______________

Address: ______________________________________

City: ______________ **State:** __________ **Zip:** __________

Phone: ______________________ **Cell:** ______________________

Date of Birth: ______________________

Referring Provider: ______________________________________

Phone: ______________________ **Fax:** ______________________

Insurance: ______________________________________

Reason for Consult: ______________________________________

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- SLEEP CONSULT- evaluate and treat
- SLEEP STUDY
- ALLERGY CONSULT
- ALLERGY TESTING

In addition to this form please send the following:
- Demographic sheet
- Office notes
- Insurance card(s)
- Any sleep studies (if patient has had prior studies)

RETURN FAX TO: (574) 534-6915 **OFFICE PHONE: (574) 534-9911**