

Obstructive Sleep Apnea Screening Referral

Please fax completed and signed form to: (833) 255-1294



WILLIAM GROSS, DDS

2733 Horse Pen Creek Road,
Suite 107, Greensboro, NC 27410

Phone: (336) 360-6359

Fax: (833) 255-1294

northcarolinassleepsolutions.com

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

Address: _____

Please check ALL that apply:

Symptoms:

- Loud Snoring
- Gasping for Air / Trouble Breathing
- Low SpO₂ Levels
- Elevated Pulse
- Daytime Sleepiness
- Other: _____

**Please screen and evaluate this patient
for possible Obstructive Sleep Apnea.**

Referring Doctor:

Print Name

Date of Referral

Signature

Email

Phone