



# Capitol Sleep Medicine

**Timothy J Walter MD**  
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**FAX REFERRAL FORM**  
**1-(800)-SNORING**

**Grove City**  
2441 Old Stringtown Rd  
Grove City, OH 43123

**Eastside**  
255 Taylor Station Rd #201  
Columbus, OH 43213

**Canal Winchester**  
11925 Lithopolis Rd NW  
Canal Winchester, OH 43110

Patient name (first and last): \_\_\_\_\_

Address: \_\_\_\_\_

City/State/zip: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Social Security number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Insurance: \_\_\_\_\_

Referring physician: \_\_\_\_\_

Coordinator \_\_\_\_\_

Referring

Referring physician phone: \_\_\_\_\_

Referring physician fax: \_\_\_\_\_

Provisional Diagnosis (Please Circle)
Obstructive Sleep Apnea (OSA)
Narcolepsy
Restless Legs
Periodic Limb Movements
Nocturnal Seizures
Abnormal Behaviors During Sleep
Other:

*Please fax completed form to 614-317-9977. We will contact the patient to schedule.*

*We will fax the scheduled appointment to you.*

***Direct Sleep Studies available upon request***

***Thank you for your referral!***