



Capitol Sleep Medicine

Timothy J Walter MD
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FAX REFERRAL FORM
Fax # (614) 317-9977

Grove City

2441 Old Stringtown Rd
Grove City, OH 43123

Columbus

4845 Knightsbridge Blvd
Suite 215
Columbus, OH 43214

Eastside

907 Creekside Plaza
Building C, 2nd floor
Gahanna, OH 43230

Patient name (first and last): _____

Address: _____

City/State/zip: _____

Home phone: _____

Work phone: _____

Social Security number: _____

Date of Birth: _____

Insurance: _____

Policy #: _____

Referring physician: _____

Referring Coordinator _____

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:

We Accept all Insurances, including Medicare, Medicaid, Medigold and OSU Health Plans

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

We will fax the scheduled appointment to you.

Call us at (614) 317-9990

Thank you for your referral!