



Capitol Sleep Medicine

Timothy J Walter MD
Uma Marar MD

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
255 Taylor Station Rd
Columbus, OH 43213

Canal Winchester
11925 Lithopolis RdNW
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: _____

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|--|
| 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.

Call us at (614) 317-9990

Thank you for your referral!