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
5969 East Broad Street
Suite 202
Columbus, OH 43213

Patient name (first and last):_____

Address:_____

City/State/zip:_____

Home phone:_____

Work phone:_____

Social Security number:_____

Date of Birth:_____

Insurance:_____

Policy #:_____

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

Referring physician:_____ Referring Coordinator_____

Referring physician phone:_____ Referring physician fax:_____

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!