INSPIRE THERAPY REFERRAL FAX FORM

Date: ________________________

TO: Dr. Scotch / Dr. Agnew / Dr. Bueller

FAX: 561-725-8788

PHONE: 813-994-8900

EMAIL: ___________________________________

FROM: ____________________________________

FAX: ______________________________________

PHONE: ___________________________________

EMAIL: ___________________________________

PATIENT INFORMATION

Name: ___________________________________

DOB: ____________________________________

Daytime Phone: ____________________________

Insurance: _______________________________

BMI: ____________________________________

Date of Last Sleep Study: __________________

AHI: ____________________________________

% Central Sleep Apnea: ____________________

CPAP History: □ Current user □ Past user

PLEASE INCLUDE

Medical history including documented CPAP use

Most recent sleep study

Demographic & insurance information

NOTES:

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Inspire therapy was FDA-approved in 2014 and is specifically for patients who are:

- Diagnosed with moderate to severe Obstructive Sleep Apnea
- Unable to use or get benefit from CPAP
- Not obese
- Age 18+