PEAK NEUROLOGY
AND SLEEP MEDICINE, LLC

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To request a consultation, please complete this form and fax along with medical records, demographic information, and copy of insurance card to: 907-331-3647. PLEASE NOTE WE DO NOT DO CONSULTS FOR DISABILITY DETERMINATION.

☐ **Graham Glass, MD** (Neurology and Sleep) ☐ **Marci Troxell, DO** (Neurology) ☐ **Robert Lada, MD** (Neurology and Sleep) ☐ **Ross Dodge, MD** (Pediatric Sleep Medicine)

☐ **Beth Baker, MD** (Sleep Medicine) ☐ **Mark Holman, Psy.D** (CBT-I) ☐ **Genevieve Corbett, ANP** (Neurology and Sleep) ☐ **Stephani Friess, FNP** (Neurology)

☐ **First Available,** our practice will identify the earliest appointment with the provider who can meet the patient's needs

Referral For (please check all that apply):

	Botulinum Toxin Injection			**Neuropathy / Nerve Disorder**			**Adult Sleep Apnea (OSA / CSA, etc.)**
	Dementia			**Parkinson's Disease**			**Excessive Daytime Sleepiness**
	Dystonia			**Seizure / Epilepsy**			**Insomnia**
	EMG / Nerve Conduction Study			**Spine / Radiculopathy**			**Restless Legs / PLMS**
	Headache / Migraines			**Stroke / TIA**			**Pediatric Sleep Disorders (will be seen by Dr. Dodge)**
	Multiple Sclerosis			**Tremor**			**Other Sleep Disorder (please specify):**
	Myoclonus			**Other Neurologic Disorder (please specify):**			
	Neuromuscular / Muscle Disorder						**Outpatient EEG**

Requested by: _____ Phone: _____ Fax: _____
(full name)

Provider NPI: _____ Address: _____

Reason(s) for consultation:

_____

_____

_____

We will contact patient directly to schedule an appointment.

Patient Name: _____ Patient DOB: _____

Patient's Primary Phone:(_____) _____ Patient's Secondary Phone:(____) _____

Name of Contact Person:_____ Contact's Phone Number:(____) _____
(If different from patient)