



2841 Debarr Rd, Suite 32 Anchorage, AK 99508

Tel. 907-331-3640

3831 Piper St, Suite SLL020 Anchorage, AK 99508

Fax. 907-331-3647

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)

Nancy Felton, ANP
(Sleep Medicine)

Beth Baker, MD
(Sleep Medicine)

Greg Gerboth, MD
(Sleep Medicine)

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):

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