ADVANCED SPECIALTY ANESTHESIA, LLC

REQUEST FOR ANESTHESIA SERVICES

Email to: referral@asasleep.com Fax: 785-422-5477

Referring Provider Office please complete below section:

Referring Office: _____ Sedation Date Requested: ____/____/____ or To Be Determined (TBD)

Reason for the Procedure: (**please circle)** Dental Caries, Accident/Injury Related, Other:_____

Estimated Treatment Time: (**please circle)** 1 hr. 90 min. 2 hr. 2 hr. 30 min. other:_____

ASA will need a copy of the medical card, Patient Medical History, Patient Authorization and current Physical with this referral

Patient Information

First Name M.I. Last Name (Nickname)

Home Address Apt. # City State Zip

Cell Phone Work/Alternate Phone Ok to contact by Text message: Y / N

Date of Birth: ____/____/____ Age: _____ Sex: M F Preferred Language_____

Parent/Guardian Information (patients 18 years of age or younger)

Does patient reside in a facility/nursing home? Yes/No *Name of Facility & Phone*_____

First Name M.I. Last Name Relationship to Patient

Home Address (if different from patient) Apt. # City State Zip

Cell Phone Number Email Address

Medical Insurance Information -Please send copy of card

Insurance Company: _____

ID Number: _____ Group Number: _____

Phone Number (for Providers – located on back of card): _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's SSN: _____

Name of Employer or Company that provides benefits: _____

_____ I give permission for Advanced Specialty Anesthesia, LLC, to leave a message regarding information relevant to anesthesia services.

Patient/Guardian Signature: _____ Date: _____