



MID-MICHIGAN DIAGNOSTICS SLEEP CENTER

Serving Genesee, Saginaw, Tuscola and Surrounding Counties

Main Office Phone: 810-606-0656 • Main Office Fax: 810-606-0662

Sleep Center Referral Form

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Phone Number: _____ Alternate Phone Number: _____

Primary Insurance: _____ Contract #: _____ Pre-Cert #: _____

Secondary Insurance: _____ Contract #: _____ Pre-Cert #: _____

Parent / Guardian Name: _____ Date of Birth: _____

Referring Physician: _____ Phone Number: _____

Clinical Information: _____

Patient Disabilities: _____

Current Medications: _____

Please Select Type of Study

- Sleep Study (Polysomnogram): CPAP if necessary
- Sleep Study (Polysomnogram): ENT Surgical Clearance Only
- Sleep Study / MSLT: Diagnosing Narcolepsy
- CPAP / BIPAP: Titration
- CPAP: Equipment if necessary

Clinical History and Indications: Please Check All That Apply

- | | | |
|---|---|---|
| <input type="checkbox"/> Excessive Daytime Tiredness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cataplexy |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Emphysema / COPD | <input type="checkbox"/> Vivid Dreams Soon After Falling Asleep |
| <input type="checkbox"/> Witnessed Apnea Episodes | <input type="checkbox"/> Depression or Bipolar Disorder | <input type="checkbox"/> Sleep Paralysis |
| <input type="checkbox"/> Early Morning Headaches | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Obesity/Recent Weight Gain |
| <input type="checkbox"/> Trouble Falling Asleep | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Previously Diagnosed Obstructive Sleep Apnea | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Stroke |
| When: _____ Where: _____ | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Any Other Special Needs: _____ | | |

Physical Exam: Please Check All That Apply

Height: ____ ft. ____ in. Weight: _____ LBS. BMI: _____ BP: ____ / ____ Neck Size: _____ in.

Nose: Clear Congested Deviated Septum Enlarged Turbinates'

Throat: Normal Large Tonsils Small Hypopharynx Redundant Tissue Large Bulky Uvula

Mandible: Normal Small Overbite

Lungs: Normal Abnormal Specify if Abnormal: _____

Heart: Normal Abnormal Specify if Abnormal: _____

Ordering Physician Signature: _____ Date: _____