McLaren Flint
Flint, MI
SLEEP DIAGNOSTIC CENTER

DIRECT REFERRAL ORDERS

COMPLETED BY OFFICE STAFF:

☐ Sleep Referral Received

☐ Health/Sleep History Questionnaire

☐ Submitted for Approval

REVIEWED BY MEDICAL DIRECTOR:

☐ Schedule patient for Sleep Consult prior to performing study
☐ Request the following test results form the referring physician _____
_____
☐ Other:_____

Yes ☐ No ☐ Meets criteria for approval of sleep study

☐ Diagnostic PSG and CPAP if needed (HST if required)

☐ Split-study

☐ CPAP Titration

☐ BiLevel Titration

☐ Follow up Titration to ensure current PAP level is therapeutic

☐ MSLT

☐ Other _____

CLINICAL INDICATION FOR SLEEP STUDY:

☐ OSA G47.33 ☐ Hypersomnia G47.10 ☐ Other _____

_____ _____
Sleep Physician Signature Date/Time

PT.

MR.#/P.M.

DR.