McLaren Flint
Flint, MI
SLEEP TESTING REFERRAL ORDER

Clinical notes are required and MUST reflect indication and medical necessity

Patients Name:_____ DOB:_____

Address:_____

Phone:_____

Requesting Provider Information:

Provider Name:_____

Phone:_____ Fax:_____

☐ Sleep Testing Requested

Information provided will be reviewed by our Medical Director to ensure appropriate sleep study is performed to diagnose, treat, or continue treatment. HST, repeat PSG or Split study may be performed if required by the patient's insurance provider.

Clinical Information: Height:_____ Weight:_____

Yes	No	
☐	☐	Home oxygen use
☐	☐	Current home CPAP/BiLevel/APAP
☐	☐	Excessive daytime sleepiness
☐	☐	Loud snoring
☐	☐	Witnessed apnea
☐	☐	Restless legs or leg jerks disturbing sleep
☐	☐	Trouble falling asleep or remaining asleep
☐	☐	Depressed or anxious
☐	☐	Hypertension
☐	☐	COPD
☐	☐	Congestive Heart Failure
☐	☐	Patient on dialysis
☐	☐	Special Needs (wheel chair, blind/deaf, interpreter, caregiver etc)

If yes, please explain: _____

_____ _____
Physician's Signature Date/Time

PLEASE SEND WITH INSURANCE INFORMATION and OFFICE NOTES
Fax to 810-342-3939

640B

PT.

MR.#/P.M.

DR.