McLAREN OAKLAND
SLEEP DIAGNOSTICS CENTER

ENCOUNTER FORM

REFERRAL DATE		PACKET MAILED / EMAILED EMAIL ADDRESS:
PATIENT NAME:		
DOB:	SS#	**ORDERING PHYS:**
ADDRESS:		PHYS PHONE: PHYS FAX:
HOME PHONE		***REFERRING** PHYS:*
ALT PHONE		*PHYS PHONE:* *PHYS FAX:*

PRIMARY INS	***SECONDARY INS***
MEMBER ID	MEMBER ID
ELIGIBILITY/BENEFITS	ELIGIBILITY/BENEFITS

	TEST #1	**TEST #2**
TEST ORDERED		
SCHEDULED DATE		
ARRIVAL TIME		
BEDROOM USED		
TECHNOLOGIST		
DVD VIEWED?		

BED TIME: AM / PM
WAKE TIME: AM / PM

WHEELCHAIR? YES / NO
HOSPITAL BED? YES / NO
CAREGIVER? YES / NO
OXYGEN? YES / NO
WAS McLAREN ONLINE SLEEP QUIZ COMPLETED? Y / N

SPECIAL INSTRUCTIONS:

PAP LEVEL:		MASK:		
EPPS:	HEIGHT:	WEIGHT:	BMI:	AHI: CPAP VISIT? Y N

PT.

MR.#/P.M.

DR.