McLAREN FLINT
Flint, Michigan 48532

SLEEP DIAGNOSTIC CENTER

PAP ENCOUNTER FORM

Patient:	
DOB:	Phone:
Physician:	Physician fax#: ( )

Test Ordered	
Scheduled Date	
Arrival Time	
Bedroom Used	
Technician	

_____
_____
_____
_____
_____

Special Instructions: _____
_____
_____
_____
_____
_____

PAP Therapy Status: ☐ accepted ☐ waiting to see physician ☐ refused	
PAP level:	Mask:

EPSS =	Height:	Weight:	AHI=

Interpreting Physician: _____

PT.

MR.#/RM.

DR.