McLAREN FLINT
SLEEP DIAGNOSTIC CENTER
Telephone (810) 342-3900 Fax (810) 342-3939

PATIENT'S SLEEP DATABASE/ORDER
(This form is required prior to scheduling sleep studies)

Patient's Name: _____ _____ Date _____ / _____ / _____

Telephone Number: _____

Please make (x) for all positive symptoms.

History

____ Excessive daytime Sleepiness
____ Loud Snoring
____ Witnessed Apnea (stop breathing during sleep)
____ Waking up with gasping or choking
____ Waking up with headaches
____ Daytime tiredness
____ Trouble falling asleep
____ Trouble maintaining sleep
____ Body paralysis triggered by emotions (Cataplexy)
____ Vivid Dreams soon after sleep onset
____ Sleep paralysis
____ Inadequate hours allotted for sleep in a day
____ Feel depressed or anxious
____ Restless legs preventing sleep
____ Leg jerks disturbing sleep
____ Other, please specify _____

Present Medical Problems

____ Congestive Heart Failure
____ Emphysema/COPD
____ Depression or Bipolar Disorder
____ Pulmonary Hypertension
____ Polycythemia
____ Atrial Fibrillation
____ Seizure Disorder
____ Other, (specify) _____
_____

Special Needs

____ Patient bringing caregiver for assistance
____ Patient uses wheelchair
____ Other (specify) _____
_____

Physical Exam

Height _____ Weight _____ Blood Pressure _____

Throat
_____ Normal
_____ Large tonsils
_____ Redundant tissue in throat
_____ Small throat
_____ Throat hard to visualize

Nose
_____ Clear
_____ Congested
_____ Diviated Septum

Legs
_____ Normal
_____ Edematous

Neck
_____ Normal
_____ Short
_____ Neck Circumference in inches

Heart
_____ Normal
_____ Abnormal

Mandible
_____ Normal
_____ Abnormal

Lungs
_____ Normal
_____ Wheezy

Test Ordered

_____ Sleep Study Screen and CPAP if necessary (HST if required by insurance)
_____ Sleep Study (Polysomnogram) only
_____ Follow-up Titration to ensure current setting is therapeutic (also PSG if required to replace equipment)
_____ Home Sleep Test (HST)_____ Other, Specify _____

Post-Test Follow-up

Unless we are informed otherwise, when the interpreting physician feels that clinical correlation for complex sleep issues is required, an appointment with one of our credentialed sleep physicians will be made.

_____ Please contact me prior to making the appointment

Ordering Physician's Signature _____ Date _____

Preferred Interpreting Sleep Physician: _____ ☐ No Preferences

Please fax this form to the Sleep Lab at (810) 342-3939

PT.

MR.#/RM.

DR.

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