McLAREN FLINT
Flint, Michigan
SLEEP DIAGNOSTIC CENTER

DIRECT REFERRAL ORDERS

Sleep Database Order Received ..... _____

Health/Sleep History Questionnaire ..... _____

Submitted for approval on ..... _____

REVIEWED BY MEDICAL DIRECTOR

Meets criteria for approval of sleep study ..... _____

Please request permission from referring Physician for Sleep consult prior to performing a sleep study ..... _____

Please request permission from referring Physician for Insomnia consult prior to performing a sleep study ..... _____

Please request the following test results from the referring physician:

_____

_____

Other:_____

_____

_____ _____
Medical Directors Signature Date

Clinical Indication for Study:

_____ OSA 32723 _____ Hypersomnia 78054 Other: _____

PT.

MR.#/RM.

DR.