McLaren
FLINT

SLEEP DIAGNOSTIC CENTER
MAILED CPAP FOLLOW-UP FORM

Name: _____ Date: _____ / _____ / _____

1. **Have you seen your physician since your sleep study was done, and discussed your sleep study results?**
❑ Yes ❑ No

   If no, we encourage you to make an appointment with your referring physician to discuss results.

2. **Were you prescribed CPAP?** ❑ Yes ❑ No

   If no, what treatment are you planning? _____

   _____

   If yes, are you having any problems with the CPAP? ❑ Yes ❑ No

   If yes, what type of problems? _____

   ❑ Mask leaks
   ❑ Mask irritation
   ❑ Noise
   ❑ Wake and take mask off
   ❑ Take mask off while sleeping
   ❑ Sinus Congestion
   ❑ Sinus Drainage
   ❑ Nasal Dryness

   ❑ Difficulty falling asleep
   ❑ Too much air
   ❑ Too little air
   ❑ Unsure
   ❑ Frequent awakenings
   ❑ Difficulty resuming sleep following awakenings
   ❑ Other: _____

3. **On average, I am wearing my CPAP _____ nights per week for about _____ hours.**

4. **Do you feel less sleepy and/or fatigued since beginning CPAP therapy?** ❑ Yes ❑ No

Please contact the Sleep Center at (810) 342 3900
to discuss any problems you are having with one of our technicians.
Many problems can be resolved with our assistance.

We look forward to hearing from you!

PT.

MR.#/P.M.

DR.