McLaren THUMB REGION

Sleep Disorders Center

Saad S. Ahmad, MD

1100 S. Van Dyke Bad Axe, Michigan 48413

AASM 2024 ACCREDITED Facility Member

SLEEP MEDICNE ORDER/REFERRAL

Phone: 989-269-1565 Fax: 989-269-1555

Patient name: _____ **D.O.B.** _____

Please send patient demographics and visit note or H&P indicating need for sleep study

Primary Insurance: _____ **Insurance authorization needed?** ☐ **yes** ☐ **no**

(if yes) Auth # _____ **For service:** _____ **Verified by (initial)** _____

DIAGNOSIS/ INDICATIONS

☐ Obstructive sleep apnea ☐ Central sleep apnea ☐ Insomnia ☐ PLMD/RLS ☐ Hypersomnia ☐ Narcolepsy

☐ Other: _____

HISTORY

☐ Excessive daytime sleepiness
☐ Loud snoring
☐ Witnessed apnea (stop breathing while asleep)
☐ Wake up gasping or choking
☐ Morning headaches
☐ Trouble falling asleep or maintaining sleep
☐ Frequent awakenings
☐ Fall asleep driving or at undesired times
☐ Body paralysis triggered by emotions
☐ Vivid dreams or hallucinations
☐ Sleep paralysis
☐ Inadequate hours allowed for sleep time
☐ Restless legs preventing sleep
☐ Feel depressed or anxious
☐ Abnormal movements during sleep
☐ Other: _____

PRESENT MEDICAL PROBLEMS

☐ Congestive heart failure
☐ COPD/ lung disease
☐ High blood pressure
☐ Coronary artery disease
☐ History of stroke
☐ Obesity
☐ Seizure disorder
☐ Depression/bipolar
☐ Currently uses CPAP/BiPAP
☐ Uses supplemental oxygen
☐ Special needs:
☐ Other: _____

PHYSICAL EXAMINATION

Height: _____ Weight: _____ BMI: _____ Neck circumferences in inches: _____

TEST ORDERED*

☐ Office Consultation with sleep specialist physician.
☐ Diagnostic Sleep Testing
  ☐ Preference for In-lab Sleep Testing ☐ Preference for Home Sleep Apnea Testing
☐ Daytime nap test (MSLT)
☐ Daytime maintenance of wakefulness test (MWT)
☐ CPAP or Bi-level PAP titration

***All referrals are reviewed to ensure applicable clinical/ insurance guidelines are followed. Comprehensive follow up offered to all patients.**

Physician Name (printed): _____ **Phone:** _____

Physician Signature: _____ **Date:** _____

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PULMONARY MEDICNE REFERRAL

Phone: 989-269-1565 Fax: 989-269-1555

Patient name: _____ **D.O.B.** _____

Patient phone: _____ **Primary Insurance:** _____

REQUESTED SERVICES

☐ Pulmonary Testing

☐ Pulmonary Function Testing ☐ 6 Minute Walk Test/Pulmonary Stress Test (for supplemental oxygen qualification)

- **For Pulmonary Testing, please send complete patient demographics, insurance information, and insurance pre-authorization (if applicable)**

☐ Pulmonary Medicine Consultation

- **For Pulmonary Testing, please send:**
  - **Complete patient demographics, insurance information, and insurance pre-authorization (if applicable)**
  - **Chest X-rays and CT scans (up to 3 years if possible)**
  - **Cardiopulmonary records (PFTs, echocardiograms, etc.)**
  - **Most recent labs**
  - **Previous sleep studies**

REASON FOR VISIT/ CHIEF COMPLAINT:

☐ COPD
☐ Shortness of Breath
☐ Asthma
☐ Pulmonary Nodule
☐ Hypoxia
☐ Pulmonary Fibrosis

☐ Other: _____

REQUESTING PROVIDER

Physician Name (printed): _____ **Date:** _____

Phone: _____ **Fax:** _____