TriCity Lung & Sleep

Saad S. Ahmad, MD

PULMONARY & SLEEP MEDICINE

f: 866-287-5136   o: 989-778-1425   www.TriCityLS.com

TESTING ORDER FORM

Patient name: ______________________________ **D.O.B.** ______________

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

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

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

SLEEP DIAGNOSIS/ INDICATIONS

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

PULMONARY DIAGNOSIS/ INDICATIONS

- ☐ Shortness of Breath
- ☐ Pulmonary Fibrosis
- ☐ COPD
- ☐ Hypoxia
- ☐ Asthma
- ☐ Other ______________

Sleep Problems *(for Sleep Medicne Referrals)*

- ☐ 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: ______________

Past Medical History

- ☐ Congestive heart failure
- ☐ COPD/ lung disease
- ☐ High blood pressure
- ☐ Cornary 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: ________

SLEEP TESTING

- ☐ Office Consultation with sleep specialist physician
- ☐ Diagnostic Sleep Testing

PULMONARY TESTING

- ☐ Pulmonary Function Testing
- ☐ 6 minute Walk Test

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:** ______________