McLaren
CARO REGION
Sleep Center

TriCity Lung & Sleep
Saad S. Ahmad, MD
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AASM
2024 ACCREDITED
Facility Member

SLEEP CENTER ORDER FORM

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
☐ 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: _____

TEST ORDERED

☐ Office Consultation with sleep specialist physician
☐ Diagnostic Sleep Testing
  ☐ Prefrence for In-lab Sleep Testing ☐ Prefrence for Home Sleep Apnea Testing
☐ INSPIRE/Alternative treatment Qualification
☐ Daytime nap test (MSLT)
☐ 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:** _____

PULMONARY MEDICNE REFERRAL

Phone: 989-672-5735 Fax: 810-600-7891

Patient Name: _____ D.O.B _____

Patient Phone: _____ Primary Insurance: _____

RQUESTED SERVICES

☐ Pulmonary Testing

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

- For Pulmonary Medicine Consultation, please send Complete patient demographics, insurance information, and insurance preauthorization (if applicable)

☐ Pulmonary Medicine Consultation

- For Pulmonary Medicine Consultation, please send:
  - Complete patient demographics, insurance information, and insurance preauthorization (if applicable)
  - Chest X-rays and CT scans (up to 3 years)
  - Cardiopulmonary (PFTS, echocardiograms, ect.)
  - Most recent labs
  - Previous sleep studies and CPAP trails

REQUESTING PROVIDER

Physician Name: _____ Date: _____

Phone: _____ Fax: _____