CENTER FOR PULMONARY & SLEEP MEDICINE

Dwayne M. Griffin, DO

Trudy E. Day, MSN, NP

Caitlyn G. Schaller, PA-C

Sarah A. Adams, PA-C

Danielle N. Cook, PA-C

Keely M. Blosh, MSN, NP

MAIN OFFICE

Burns Professional Building
560 W. Mitchell St Suite 505
Petoskey, MI 49770

BRANCH LOCATIONS

McLaren Northern MI
Cheboygan, Campus
802 S Main, Suite 3
Cheboygan, MI 49721

McLaren Specialty Clinic Building
930 N. Center Street
Gaylord, MI 49735

Office: (231) 487-2100

Billing: (231) 487-2183

Fax: (231) 487-1909

CERTIFIED AMERICAN BOARD OF SLEEP MEDICINE

BOARD CERTIFIED IN PULMONARY MEDICINE

BOARD CERTIFIED IN CRITICAL CARE MEDICINE

INBOUND REFERRAL FORM

Referral From: ______________________________ Phone: ____________________

Referral to: ____
Leave blank if no specific provider requested and CPSM will complete

Patient Name: ________________________________ DOB: ________________

Reason for referral: ____

When using this form, the following information MUST accompany the request:

- All Patient Demographic and Insurance information
- Copies of any pertinent Medical Records
- Relevant Diagnostic Test Results
  - Previous Sleep Studies
  - Laboratory Results
  - Cardiac Studies
  - Pulmonary Function Tests
  - Radiologic Studies – Chest Films, Chest CT (Including any previously done, for comparison)
  - Any other information you deem pertinent

For Tests performed outside of McLaren Northern-Michigan Hospital, PLEASE have the patient HAND CARRY the actual films or CD(s) to their appointment.

This form will be faxed back to the referring provider with the appointment date and time contingent on the above information being received. CPSM will notify the patient of their appointment date/time.

Your patient's appt. is scheduled for ____________________ at _____________

In our office located in ____

Thank you for referring your patient to the Center for Pulmonary & Sleep Medicine!