McLaren
THUMB REGION

# Sleep Disorders Center
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AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE — SLEEP
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
☐ 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:** __________