SLEEP & LIVE WELL DIAGNOSTIC CENTER

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AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE — SLEEP
ACCREDITED MEMBER CENTER

43650 Garfield ● Clinton Township, MI 48038 ● Phone (586) 263-0820 ● Fax (586) 263-3819 ● www.sleepandlivewell.com

PATIENT INFORMATION

NAME: _____ DOB: _____/_____/_____

ADDRESS: _____ HT: _____ WT: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____-_____-_____

INSURANCE: _____ GROUP ID #: _____ MEMBER ID #: _____

PLEASE FAX A COPY OF PREVIOUS SLEEP STUDY RESULTS (IF ANY)

INSTRUCTIONS TO REFERRING PHYSICIANS: Please check the services requested and return by ***fax to (586) 263-3819.*** We will contact the patient to schedule the tests you have ordered. Thank You.

- ☐ Sleep evaluation (***prior to sleep study***)
- ☐ Office visit (***after sleep study)*** for review of results and management of sleep problems
- ☐ Sleep testing only (***Referring physician to discuss results and manage sleep problems) (Fax office note)***
- ☐ Baseline Polysomnogram
- ☐ Baseline Polysomnogram with Continuous Positive Airway Pressure (CPAP) Titration (if indicated)
- ☐ Baseline Polysomnogram with Multiple Sleep Latency Test (suspected narcolepsy)
- ☐ Baseline Polysomnogram with Oral Appliance (determine the effectiveness of an oral appliance)
- ☐ Continuous Positive Airway Pressure (CPAP) Titration
- ☐ Continuous Positive Airway Pressure (CPAP) Re-Titration
- ☐ Split Night (presentation or suspicion of severe OSA with an AHI >40)
- ☐ PAPNAP (intolerant of PAP pressure, claustrophobia, anxiety, or cannot fall asleep with PAP therapy)
- ☐ MWT (quantifies wake tendency by measuring the ability to remain awake during soporific circumstances)
- ☐ Other: _____

REASON FOR PATIENT REFERRAL:

- ☐ Snores or stops breathing at night
- ☐ Wakes up gasping for air
- ☐ Witnessed apneas
- ☐ Excessive daytime sleepiness or fatigue
- ☐ Abnormal behaviors during sleep
- ☐ Morning headaches
- ☐ Other: _____

SPECIAL CONSIDERATIONS:

- ☐ Patient requires oxygen during the night at __ lpm
- ☐ Patient requires a caregiver to stay overnight
- ☐ Patient requires wheelchair access / side bed rails
- ☐ Patient requires use of recliner
- ☐ Shift worker / needs a daytime sleep study
- ☐ Other: _____
- ☐ Other: _____

PLEASE NOTE THAT INSURANCE AUTHORIZATION IS DEPENDENT ON THIS INFORMATION:

☐ Obesity-Hypoventilation	☐ Obesity	☐ Nasal Obstruction	☐ Cardiac arrhythmia
☐ COPD/Chronic Lung Disease	☐ Seizures	☐ Neuromuscular disease	☐ Neurodegenerative / Cognitive Impairment
☐ Acute MI ____/____/____	☐ CHF/CAD	☐ Stroke/TIA ____/____/____	☐ Moderate to severe pulmonary disease
☐ Hypertension	☐ OSA	☐ Nocturnal hypoxemia	☐ Other: _____

ORDERING PHYSICIAN: _____ PHONE: _____

ADDRESS: _____ FAX: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

SLEEP PHYSICIAN SIGNATURE: _____ DATE: _____

REFERRING PHYSICIAN SELECT PREFERENCES - Send report by: ☐ Fax ☐ Mail ☐ Call with test results