Sound a Sleep
SLEEP DIAGNOSTIC LAB

REFERRAL FORM TO BE FAXED

Patients Name: _____ DOB: _____ M / F

Address: _____

Cell Phone #:_____ Home Phone: _____ Work:_____

Insurance Info: _____ Email: _____

☐ Evaluate & Treat ☐ Home Study ☐ In-Lab Study ☐ Titration Study ☐ Split Study

LOCATION: ☐ **Saginaw** ☐ **Midland** ☐ **Bay City** ☐ **Mt Pleasant**

___ Adult ___Child

___ BMI > 30 BMI _____

___ Currently using CPAP/BIPAP/ASV

Current DME/CPAP Supplier: _____

Preferred DME/CPAP Supplier: _____

___ Snoring

___ Enlarged Tonsils

___ Excessive Daytime Sleepiness

___ Witnessed apneas/choking/gasping

___ Restless/unrefreshed sleep

___ Fragmented sleep

___ Restless legs / Tossing & Turning

___ Irritability

___ Diabetes

___ Heart Disease/CAD/CHF/A-Fib

___ Cardiac Arrhythmia

___ Pacemaker/Defibrillator

___ Hypertension

___ Hypothyroidism

___ Pulmonary Hypertension

___ Asthma/COPD/Emphysema

___ Home Oxygen

Oxygen Supplier: _____

___ Poor Cognition / Memory / Concentration

___ Neuromuscular Disease (ALS/MS/TIA/Stroke)

___ Seizure Disorder

___ Depression/Anxiety/ADHD/PTSD

___ Suspected Narcolepsy

___ Suspected Parasomnia

___ Suspected Central Sleep Apnea

___ Chronic Pain

___ Fibromyalgia

___ On Narcotic Medications

Referred by (Print Name): _____Date: _____

Please fax this form to (989)792-1792 or (989)793-7113