UP HEALTH SYSTEM
SLEEP DISORDERS CENTER

890 Campus Drive, Suite B.
Hancock, MI 49930
Phone: 906-483-1950

DIRECT REFERRAL FORM
Please complete and fax this form to (906)483-1960 with current patient demographics, insurance information and history/progress notes.

PATIENT INFORMATION

Name:_____ DOB:_____ Gender:____

Height: _____ Weight: _____ Neck Circumference (inches): _____ Most recent bicarb/CO2:_____

☐ Commercial Driver's License (CDL)

☐ Sleep Questionnaire given to patient at appointment to return to Sleep Center.

STUDY TYPE -- Please check one of the following:

☐ **Diagnostic study –** will perform split night, if possible.

☐ **Titration study**

****** PATIENT HISTORY AND PHYSICAL EXAM DOCUMENT IS REQUIRED FOR SLEEP STUDY. ******

REMINDERS:

1. Please let your patient know that you are requesting a sleep disorder evaluation or a sleep study.
2. Must be included for sleep study: clinic note MUST contain indication for study and a detailed sleep history. Physical exam (neuro, ENT, CV, weight, VS, and neck circumference), and functional limitations related to sleep disturbance.

Medical Conditions (check all that apply):

☐ Hypertension
☐ Treatment resistant
☐ Cardiac arrhythmias
☐ CHF
☐ Stroke
☐ COPD
☐ Asthma
☐ Depression
☐ Neuromuscular disorder
☐ Seizures
☐ GERD
☐ Diabetes
☐ Fibromyalgia
☐ Thyroid dysfunction
☐ Coronary artery disease
☐ Heart attack
☐ Stent
☐ Obesity
☐ Cerebral palsy
☐ Other:_____

Patient Name_____

Presumptive Diagnosis (Check all that apply):

- ☐ Sleep apnea, unspecified
- ☐ Obstructive sleep apnea
- ☐ Sleep hypoventilation/hypoxemia
- ☐ Insomnia
- ☐ Narcolepsy
- ☐ Hypersomnia
- ☐ Loud snoring
- ☐ Shift work disorder
- ☐ Sleep walking
- ☐ Periodic limb movement disorder
- ☐ Restless legs syndrome
- ☐ Other (please specify): _____

Special Needs:

- ☐ Nocturnal O2 level _____
- ☐ Wheelchair/assistance walking or transferring
- ☐ Incontinence problems
- ☐ Other
- ☐ Interpreter, language
- ☐ Tape, latex or talc allergy
- ☐ Guardian/parent/custodian

_____

_____

Ordering physician:_____

Signature Printed Name Date

***** Do not write below this line. Sleep Center use only. *****

Study Order: ☐ Approved ☐ Denied

Recommendations/Comments:

_____

Sleep Center Director:_____

Signature Printed Name Date