McLaren
CARO REGION

TriCity Lung & Sleep
Saad S. Ahmad, MD
401 N. Hooper St Caro, Michigan 48723
tel (989) 672-5111 fax (989) 672-0057

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:** _____

# TriCity Lung & Sleep

## Saad S. Ahmad, MD

### PULMONARY & SLEEP MEDICINE

f: 866-287-5136 o: 989-778-1425 www.TriCityLS.com

**PULMONARY CONSULTATION/ TRANSFER OF CARE FORM**

☐ **Requesting Consultation for an opinion/recommendation (code as Consultation)**
Please complete this form and fax back with all reports. Appointments will be made after we obtain all information below. We will notify you with the date and time of appointment. Thank you!

- **Chest X-rays and CAT scans as far back as possible (up to 3 years)**
- **Cardiopulmonary (PFTS, echo, stress tests, cardiac cath)**
- **Most recent dictated letter**
- **Most recent labs**
- **Previous sleep studies and CPAP trails**

First appointment will be scheduled in our Bay City location. Satellite clinics are held in West Branch and Bad Axe. Follow-up appointments may be held at these clinics according to availability. **Please call us if you have any questions: 989-778-1425**

**REFERRING INFORMATION**

Today's date: _____

Physician requesting consultation/services: _____

Contact person: _____

Phone: _____ Fax: _____

**PATIENT INFORMATION**

Patient name: _____

Date of birth: _____ Patient phone number: _____

Address: _____
STREET CITY STATE
ZIP

Reason for visit/Chief complaint: _____

**INSURANCE INFORMATION** *(if patient needs insurance referral, it must be done before appointment is given)*

Primary: _____ Secondary: _____

***Office use only***

Appt date: _____ Appt time: _____ Papers sent: _____ In EHR: _____

PFT Ordered: _____ PFT sched date: _____ Time: _____