McLaren Business Products

McLaren Print System Order

Order No: 46211
Order Date: 2019-06-14
User: Andrea Bennett
Phone: 342-3900

Ship Location: Mclaren Flint Beechill Ctr
G3200 Beecher Rd
Flint, MI 48532

Forms
Quantity: 500
Paragon Dept No: 36110
Dept Name: Sleep Center
Company Number: 60

Order Total Price: 0.00

Item Number: M-2628
Item Description: Patients Sleep Database / Order
Revision Date: 4/2017
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info:

MCLAREN FLINT
SLEEP DIAGNOSTIC CENTER
Telephone [illegible] Fax [illegible]

PATIENT'S SLEEP DATABASE/ORDER
(This form is required prior to scheduling sleep studies)

Patient's Name ______________________ Date ____ / ____ / ____

Telephone Number ______________________

Please make (x) for all positive symptoms.

History
- ____ Excessive daytime Sleepiness
- ____ Loud Snoring
- ____ Witnessed Apnea (stop breathing during sleep)
- ____ Waking up with gasping or choking
- ____ Waking up with headaches
- ____ Daytime tiredness
- ____ Trouble falling asleep
- ____ Trouble maintaining sleep
- ____ Body paralysis triggered by emotions (Cataplexy)
- ____ Vivid Dreams soon after sleep onset
- ____ Sleep paralysis
- ____ Inadequate hours allotted for sleep in a day
- ____ Feel depressed or anxious
- ____ Restless legs preventing sleep
- ____ Leg jerks disturbing sleep
- ____ Other, please specify ______________

Present Medical Problems
- ____ Congestive Heart Failure
- ____ Emphysema/COPD
- ____ Depression or Bipolar Disorder
- ____ Pulmonary Hypertension
- ____ Polycythemia
- ____ Atrial Fibrillation
- ____ Seizure Disorder
- ____ Other, (specify) ______________

Special Needs
- ____ Patient bringing caregiver for assistance
- ____ Patient uses wheelchair
- ____ Other (specify) ______________

Physical Exam
Height ________ Weight ________ Blood Pressure ______________

Throat
- ____ Normal
- ____ Large tonsils
- ____ Redundant tissue in throat
- ____ Small throat
- ____ Throat hard to visualize

Legs
- ____ Normal
- ____ Edematous

Heart
- ____ Normal
- ____ Abnormal

Neck
- ____ Normal
- ____ Short
- ____ Neck Circumference in inches

Mandible
- ____ Normal
- ____ Abnormal

Nose
- ____ Clear
- ____ Congested
- ____ Deviated Septum

Lungs
- ____ Normal
- ____ Wheezy

Test Ordered
- ____ Sleep Study Screen and CPAP if necessary (HST if required by insurance)
- ____ Sleep Study (Polysomnogram) only
- ____ Follow-up Titration to ensure current setting is therapeutic (also PSG if required to replace equipment)
- ____ Home Sleep Test (HST) ____ Other, Specify ______________

Post Test Follow-up
Spec Info: [illegible] otherwise, when the interpreting physician feels that clinical correlation for complex sleep issues is [illegible], an appointment with one of our credentialed sleep physicians will be made.
____ Please contact me prior to making the appointment

Ordering Physician's Signature ______________ Date ________
Preferred Interpreting Sleep Physician: ______________ ☐ No Preferences
Please fax this form to the Sleep Lab at [illegible]

PATIENT'S SLEEP DATABASE/ORDER

6408