

**Dearborn Sleep Lab**  
*Division of Millennium Medical Group South, P.C.*  
**18100 Oakwood Blvd., Suite 310**  
**Dearborn, MI 48124**  
**Phone 313-438-9800 • Fax 313-438-9801**

**PHYSICIAN REFERRAL FOR SLEEP STUDY**

Your patient has been referred to us for a sleep study. The American Academy of Sleep Medicine requires that we have the information below in each patient's chart. Please complete this form for your patient and return **within 48 hours** to us. Our fax number is **313-438-9801**. If you have any questions, our phone number is **313-438-9800**. **THANK YOU.**

**TODAY'S DATE:** \_\_\_\_\_

**PATIENT'S PERSONAL INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Height: \_\_\_\_\_ Patient's Weight: \_\_\_\_\_ DOS: \_\_\_\_\_

**REFERRING PHYSICIAN INFORMATION**

Requesting Physician: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**HISTORY AND PHYSICAL INFORMATION**

**History of Sleep Problem**

- |       |  |  |
|-------|--|--|
| _____ | <input type="checkbox"/> Excessive Daytime Sleepiness                        | <input type="checkbox"/> Shift Work      |
| _____ | <input type="checkbox"/> Morning Headaches                                   | <input type="checkbox"/> Cataplexy       |
| _____ | <input type="checkbox"/> Snoring   | <input type="checkbox"/> Nocturia        |
| _____ | <input type="checkbox"/> Witnessed Apneas                                    | <input type="checkbox"/> Sleep Paralysis |
| _____ | <input type="checkbox"/> Claustrophobia                                      | <input type="checkbox"/> Insomnia        |
| _____ | <input type="checkbox"/> Frequent Awakenings                                 | <input type="checkbox"/> Sleepwalking    |
| _____ | <input type="checkbox"/> <b>DOES PATIENT HAVE PREVIOUS DIAGNOSIS OF OSA?</b> |  |
| _____ | <input type="checkbox"/> <b>IS PATIENT CURRENTLY USING CPAP?</b>             |  |

**Medical Conditions**

- |       |  |                                       |
|-------|--|---------------------------------------|
| _____ | <input type="checkbox"/> Cardiac Arrhythmias | <input type="checkbox"/> GERD         |
| _____ | <input type="checkbox"/> CHF                 | <input type="checkbox"/> Diabetes     |
| _____ | <input type="checkbox"/> ALS                 | <input type="checkbox"/> Asthma/COPD  |
| _____ | <input type="checkbox"/> Stroke/Weakness     | <input type="checkbox"/> Chronic Pain |
| _____ | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Fibromyalgia |

**Patient Name:** \_\_\_\_\_

**Current Medications – IF NONE, PLEASE INDICATE**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physical Exam**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HEENT  
Nasopharynx:  
Oropharynx:  
Jaw/Mouth:  
Tongue:  
Dentition/Mucosa:  
Neck:  
Heart/Lungs:  
Neurologic Exam:

**REASON(S)/STUDY TYPES**

- |  |  |
|--|--|
| <b>Type</b><br><input type="checkbox"/> Screening Test<br><input type="checkbox"/> CPAP/Bipap Titration<br><input type="checkbox"/> Split-night (if indicated) | <input type="checkbox"/> MSLT/MWT<br><input type="checkbox"/> Post-Surgical Screening Test<br><input type="checkbox"/> Other _____ |
|--|--|

**DIAGNOSIS AND SPECIAL NEEDS**

**Diagnosis**

- |       |  |                                      |                                   |
|-------|--|--------------------------------------|-----------------------------------|
| _____ | <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Narcolepsy  | <input type="checkbox"/> Seizures |
| _____ | <input type="checkbox"/> PLMD/Restless Legs      | <input type="checkbox"/> Hypersomnia | <input type="checkbox"/> ALS      |
| _____ | <input type="checkbox"/> Sleepwalking/RBD        | <input type="checkbox"/> Shift Work  | <input type="checkbox"/> Insomnia |


**Special Needs**

- |       |   |  |
|-------|---|--|
| _____ | <input type="checkbox"/> Oxygen _____ Liters Per Minute | <input type="checkbox"/> Assistance Moving |
| _____ | <input type="checkbox"/> Difficulty Communicating       | <input type="checkbox"/> Medications       |
| _____ | <input type="checkbox"/> <b>Other</b> _____             |  |

**Reading Physician**

Please select the sleep specialist you wish to interpret your patient's test.

- Mamdouh Abdulrazzak, MD, ABSM
- Mohamad Al-Jarrah, MD, ABSM
- Samer Kheirbek, MD
- Devinder Mahajan, MD, ABSM, FCCP

 \_\_\_\_\_  
Ordering Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approval by Designated Sleep Staff Physician

\_\_\_\_\_  
Date