



GREATER LANSING

Sleep & Alertness Center
2727 S Pennsylvania Ave, Lansing, MI 48910

Referral Information and Order Form

Scheduling Phone: 517-975-3387
Fax: 517-975-3390
Main Phone: 517-975-3375

<https://www.mclaren.org/lansing/SleepCenterReferralFormOnlineGL.aspx>

Per Medicare LCD 4-1-2010: CPAP will NOT be covered by insurance unless the patient's physician has seen the patient face-to-face **PRIOR** to their baseline sleep test. Please include/fax the patient's most recent H&P (within 4 months).

Patient Information :-

Name:		SS#:	DOB:	
Address:		City:	State:	Zip:
Phone #1:	Phone #2:		Insurance:	

Symptoms/Diagnosis :-

I have seen the patient face to face, and signs/symptoms include:-

- | | | | | |
|---|---|---|--|----------------------------------|
| <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Periodic Limb Movements | <input type="checkbox"/> Excessive Sleepiness | <input type="checkbox"/> Depression | <input type="checkbox"/> Restless Sleep | |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Nocturnal Choking | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Memory Problems | |
| <input type="checkbox"/> Re-Eval. of CPAP/BiLevel | <input type="checkbox"/> Morning Headaches | <input type="checkbox"/> Post-Op or OTHER (specify) _____ | | |

Study/Service Type :-

- Sleep Study / Polysomnogram [95810]**
(In-lab sleep study. Subsequent sleep studies/clinic consultation will be ordered as needed.)
- Multiple Sleep Latency Testing [95805]**
(R/O Narcolepsy and to assess unexplained sleepiness, includes & requires in-lab sleep study.)
- Maintenance of Wakefulness Test [95805]**
(To assess daytime alertness, pre and/or post treatment.)
- Unattended Home Sleep Testing [95806]**
(Home sleep study. Subsequent in-lab titration/clinic consultation will be ordered as needed.)
- Home Oximetry Screening [94762]**
(To assess the need for supplemental oxygen at night.)
- Sleep Clinic Appointment**
(Consultation with a sleep physician, who will order a testing as needed.)

Other special instructions: _____

Ordering Physician's Signature: _____ Date: _____ Time: _____

Ordering Physician:	Phone:	Fax:
Office Address:		Suite#:
City:	State:	Zip:
Patient's Primary Care Physician:		

Information below for Sleep & Alertness Center use only:

Study Date/Time : _____ Clinic Date/Time: _____
 Patient Packet - Mailed Given Faxed to Patient on Date: _____ by _____ H&P received
 Prior Auth Needed :- Yes No Prior Auth Received :- Yes No
 Dates Called:



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