Toll Free: 877-595-1090
Fax: 989-345-3163

Advanced
Sleep Diagnostics
of Michigan
www.michigansleep.com

PROVIDER REFERRAL FORM

Please circle location :

☐ **Lansing** - *formerly Life Care Sleep and Health Center*
7200 W. Saginaw Hwy #2
Lansing, MI 48917
Ph: 517-323-9624

☐ **Okemos**
2525 Jolly Road Suite 240
Okemos, MI 48864
Ph: 517-879-4792

Date:_____ **Referral Source Contact Person/Faxed BY:**_____

Patient Name:_____ **DOB:**_____
Address:_____ **CIty:**_____
Ph #:_____ **Cell #:**_____
Insurance Provider: _____ **Insurance Id:**_____
If patient is a MINOR- Parents/Guardian Name(S):_____

Referring Provider Information:

Provider Name: (please print):_____PH #:_____

Clinic Name/Address: _____

☐ **EVALUATE AND TREAT: INITIAL OFFICE VISIIT & TREATMENT AS NEEDED**

REASON FOR REFERRAL: (Or may check/circle below)

☐ Excessive Daytime Sleepiness
☐ Witnessed Sleep Apnea / Snoring
☐ Disruption of Sleep Cycle
☐ Restless Leg Syndrome
☐ Sleep Walking or Night Terrors
☐ Nocturnal Enuresis
☐ Respiratory Distress During Sleep
☐ Atrial Fibrillation and other Cardiac Arrhythmias
☐ Hypertension / Cardiac Dx
☐ Pending Surgery
☐ ADHD Symptoms or Behavior Issues
☐ Academic under Performance Especially under reading and or Math's.

Thank You for Your Referral!!!

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Please circle location :

☐ **West Branch**
565 Progress Street, Suite A
West Branch, MI 48661

☐ **Gaylord**
1050 South Otsego Suite B
Gaylord, MI 49735

☐ **Saginaw**
4707 East McLeod Street Suite A
Saginaw, MI 48603

Date:_____ **Referral Source Contact Person/Faxed BY:**_____

Patient Name:_____ **DOB:**_____
Address:_____ **CIty:**_____
Ph #:_____ **Cell #:**_____
Insurance Provider: _____ **Insurance Id:**_____
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