



PHYSICIAN REFERRAL FORM

Thank you for referring your patient to Great Lakes Airway & Sleep.

Please complete this form and securely fax/email it with relevant clinical records and sleep study.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Phone: _____

Email: _____

REFERRING PROVIDER

Physician/Provider Name: _____ NPI: _____

Practice Name: _____ Phone: _____

Fax: _____

Email: _____

REFERRAL INFORMATION

Reason for Referral: ☐ Oral Appliance Therapy ☐ OSA ☐ Snoring / Sleep-Disordered Breathing ☐ CPAP Intolerance ☐ Alternative to PAP
☐ Other: _____

Diagnosis: ☐ Obstructive ☐ Central ☐ Mixed / Complex ☐ Suspected ☐ Unknown

Sleep Study: ☐ Yes ☐ No ☐ Pending

Date: _____ Type: ☐ HSAT ☐ PSG ☐ Other: _____

RECORDS TO ACCOMPANY REFERRAL

- ☐ Sleep Study Report with Interpretation & Diagnosis
- ☐ Most Recent Clinical Progress Notes
- ☐ Relevant Medical History & Current Medications
- ☐ CPAP/BiPAP History & Reason for Intolerance
- ☐ Letter of Medical Necessity (LOMN) & Prescription for Oral Appliance Therapy

PROVIDER AUTHORIZATION

Provider Signature: _____

Date: _____

PLEASE SEND REFERRAL & RECORDS TO

GREAT LAKES AIRWAY & SLEEP | Dr. Haley Lawrence, DDS

Fax: (734) 361-3948 Secure Email: hello@greatlakeairwayandsleep.com

Phone: 734-335-0820