Form # 11393 (10/16)

MUNSON MEDICAL CENTER
Sleep Disorders Center

MUNSON HEALTHCARE

REFERRAL FORM
MUNSON SLEEP DISORDERS CENTER CLINICS

Consult to be scheduled at:

❑ **TRAVERSE CITY** ❑ **GRAYLING** ❑ **CADILLAC**

Patient Name: ______________________________________ Date of Birth: ____________

Daytime Phone: __________________________ Best time to contact: ____________________

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Referring Physician (Please print): ____

Physician Phone: ________________________________ Fax: _________________________

Physician Signature: ______________________________ Date: _________ Time: _________

The following information must be received by Munson Sleep Disorders Center prior to your patient being scheduled for consultation with sleep specialist:

- **Completed and signed MSDC Referral Form**
- **Patient Demographic information**
- **Patient Insurance information**
- **H & P / office notes**
- **Prior Authorization * obtained for consult with sleep specialist**
  - *** when patient's insurance plan requires Prior Authorization**

Fax to: Munson Sleep Disorders Center at 231-935-9300

If you have any questions, please call 231-935-9307