MUNSON MEDICAL CENTER
Sleep Disorders Center
MUNSON HEALTHCARE

MUNSON SLEEP DISORDERS CENTER
REFERRAL FORM FOR AN OVERNIGHT PULSE OXIMETRY TEST

Patient Name: _____ Date of Birth: _____

Daytime Phone: _____ Best time to contact: _____

Diagnostic Requisition/Referral

☐ I, the referring physician, approve an Overnight Pulse Oximetry Test based on Munson Sleep Disorders Center approved protocols.

Referring Physician (Please print): _____

Physician Phone: _____ Fax: _____

Physician Signature: _____ Date: _____ Time: _____

This completed and signed pulse oximetry referral form along with the patient demographics and insurance information must be received prior to our scheduling your patient.

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

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