

PEDIATRIC SLEEP CENTER REFERRAL FORM

Patient Name: _____ DOB: _____ M F Height: _____ inches Weight: _____ lbs
 Parent/Guardian Name: _____
 Patient Address: _____ Email: _____
 Phone: _____ (home) _____ (work) _____ (cell)
 Secondary Contact Phone Number: _____

INSURANCE INFORMATION:

Insurance Type: HMO MCAL MCAL HMO CCS PPO EPO POS OTHER _____
 Authorization Required: NO YES

SUSPECTED DIAGNOSIS: _____

PRIOR POLYSOMNOGRAPHY TEST: NO YES

OUTPATIENT HISTORY AND PHYSICAL RECORD

MEDICAL/SLEEP HISTORY/SYMPTOMS (check appropriate boxes):

- Excessive sleepiness Insomnia Snoring Obstructive Apnea Central Apnea Overweight Seizures
- Nightmares Sleep walking Bruxism REM behavior disorder Leg cramps, movements/jerks
- CPAP compliance problems S/P UPPP; laser-assisted palatoplasty Dental appliance to advance mandible/tongue

CURRENT MEDICATIONS: _____

PHYSICAL FINDINGS

General: Normal Abnormal: _____
 Nasal passage: Clear Obstructed Rhinitis/sinusitis Other _____

TONSILLAR SIZE:

- 0 [Tonsils fit within tonsillar fossa]
- 1+ [Tonsils occupy <25% of space between pillars]
- 2+ [Tonsils occupy <50% of space between pillars]
- 3+ [Tonsils occupy <75% of space between pillars]
- 4+ [Tonsils occupy >75% of space between pillars]
- Removed
- Unknown

PHARYNGEAL SIZE (MALLAMPATTI SCORE):

- Class I [Visualization of soft palate, fauces, uvula, anterior and posterior pillars]
- Class II [Visualization of soft palate, fauces, uvula]
- Class III [Visualization of soft palate and base of uvula]
- Class IV [Soft palate not visible at all]
- Unknown

Tongue: Normal Enlarged Retracted
 Mandible: Normal Short
 Lungs: Normal Abnormal: _____
 Heart: Normal Abnormal: _____ Hypertension _____ Arrhythmia (specify): _____
 Abdomen: Normal Abnormal: _____
 Neurologic: Normal Abnormal: _____
 Extremities: Normal Abnormal: _____
 Endocrine: Normal Abnormal: _____
 Musculo-skeletal: Normal Abnormal: _____
 Behavioral/Psychiatric: Normal Abnormal: _____

STUDY REQUESTED (check appropriate box):

Sleep study; All night diagnostic PSG/Initial sleep clinic and follow-up consults. **95810**

All night CPAP titration; CPAP titration/PSG when OSA or UARS already documented. **95811**

****Previous study date**:** _____

(Tolerance to CPAP mask must have been demonstrated prior to titration study)

Narcolepsy study; All night sleep study with next day MSLT (Multiple Sleep Latency Test). **95810 + 95805**

MSLT only **95805**

Other: _____

SPECIAL NEEDS (check appropriate boxes):

Respiratory disorder Supplemental oxygen: _____ L/min _____ 24 hr _____ Nocturnal

Tape, latex or talc allergy Incontinence problems Walker, wheelchair, assistance walking

Psychiatric problems that may affect study (specify) : _____

Medications: Oral and injectable medications can only be self-administered in the Sleep Lab. They may not be administered by sleep lab technologists.

OTHER ISSUES THAT MIGHT AFFECT PATIENT COMFORT/SAFETY (specify):

ARE INTERPRETATION SERVICES REQUIRED? Yes No

If yes, which language? _____

REQUESTING PHYSICIAN: _____ **DIGITAL SIGNATURE:** _____

Date: _____ Phone: _____ Fax: _____

OFFICE USE ONLY

- Schedule for Sleep Lab
- Schedule for Sleep Clinic; send questionnaire and diary
- Schedule for CPAP mask desensitization
- Schedule for Child Life orientation

	Received	MD	Auths	Schedule
Initial:				
Date:				

SUBMIT BY EMAIL