Pediatric Sleep Disorders Program
Self Referral Form

ACCREDITED MEMBER CENTER

Miller Children's Hospital Long Beach
MemorialCare Health System

INSTRUCTIONS: Please complete this form online and press "submit" or print out and fax to (562) 933-9297.

Patient Name: _____ DOB: _____ ❑ M ❑ F Height: _____ Weight: _____

Patient Guardian Name: _____

Patient Address: _____

Phone: _____(home) _____(work) _____(cell)

Email: _____

Language Spoken: _____

What insurance does your child have:

Name: _____

Check One: ❑HMO ❑MCAL HMO ❑CCS ❑PPO ❑EPO ❑POS ❑Other: _____

Authorization Required: ❑NO ❑YES (If yes, please schedule an appointment with your child's pediatrician to get an auth.)

Briefly describe your child's sleep problems: _____

_____

_____

Has your child had a sleep study or seen a sleep specialist before? ❑Yes ❑No

Check appropriate all that apply:

❑Excessive sleepiness ❑Insomnia ❑Snoring ❑Apnea ❑Overweight ❑Seizures
❑Nightmares ❑Sleep walking ❑Teeth Grinding ❑Leg cramps, movements/jerks

Current Medications: _____

_____

History of surgeries and hospitalization: _____

_____

Special Needs:

❑Respiratory disorder ❑Supplemental oxygen: _____L/min _____24 hr _____Night only
❑Tape, latex or talc allergy ❑Incontinence problems ❑Walker, wheelchair, assistance walking
❑Psychiatric problems ❑Other:

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:				

SUBMIT BY EMAIL