Saint Alphonsus Health System

SLEEP DISORDERS CENTER OUTPATIENT ORDER FORM (PEDIATRIC)

Centralized Scheduling: 367-8787 Fax: 367-7788

Patient Name	DOB	☐ M ☐ F	Patient Phone
Insurance Provider	Diagnoses, Sign or Symptom (Narrative Required):		
Preauthorization Number(s) per procedure			
Exam Date / / Exam Time am/pm	CC:		
☐ Call patient to schedule exam	Schedule by (date)		
Contact Person at Office	Office Fax		Office Phone
Provider Name	**Provider Signature**		**Date/Time**

REFERRAL FOR SLEEP CONSULTATION WITH PEDIATRIC SLEEP SPECIALIST

This form not needed, follow standard request for consultation process.

DIRECT REFERRAL FOR SLEEP STUDY (select one)

☐ Pediatric Sleep Specialist to complete follow up and order additional testing as indicated.
☐ Referring physician will complete follow up and will order any additional testing as indicated.

INDICATIONS FOR TESTING (check all that apply)

☐ Snoring or noisy breathing
☐ Mouth Breathing
☐ Excessive sleepiness/fatigue
☐ Restlessness
☐ Daytime irritability or hyperactivity
☐ Obesity
☐ Observed Apneas
☐ Gasping/Choking during sleep
☐ Difficulty Breathing
☐ Bed wetting
☐ Failure to thrive
☐ Sleepwalking
☐ Poor School Performance
☐ Other: ____________________
☐ Nocturnal seizures
☐ Circadian Rhythm Problems
☐ Craniofacial Abnormality
☐ Adenotonsillar hypertrophy
☐ Gastroesophageal reflux
☐ T & A or other airway surgery

CHECK STUDIES DESIRED

☐ Nocturnal PSG – Baseline
☐ Nocturnal PSG with a CPAP Titration
☐ Nocturnal PSG with BiLevel Titration
☐ Nocturnal PSG with Tracheotomy
(CO_2 Monitoring Standard of Care for Pediatrics)

DAYTIME STUDIES

☐ Multiple Sleep Latency Test

PRIOR SLEEP STUDIES?

☐ Yes ☐ No
Where? ____________________
When? ____________________

SPECIAL NEEDS OR INSTRUCTIONS

☐ Supplemental oxygen ________ L/min
☐ Family member to accompany
☐ Assistance in/out of bed
☐ Seizure Montage
☐ Fall Risk
☐ Self Injurous behavior

☐ Other: ____________________

***PLEASE NOTE: MEDICATIONS ARE NOT DISPENSED AT THE SLEEP DISORDERS CENTER!**

THANK YOU FOR THE REFERRAL

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