PEDiATRIC SLEEP STUDY FORM

PATIENT INFORMATION

Patient’s Name: ____________________________ Sex: □ M □ F Home Phone: ____________________________

Insurance Carrier: ____________________________ Cell Phone: ____________________________

DOES YOUR CHILD:

Snore and/or sleep with mouth open? □ Yes □ No

Have trouble concentrating in school? □ Yes □ No

Gasp or stop breathing during sleep? □ Yes □ No

Have nightmares/night terrors? □ Yes □ No

Have ADHD? □ Yes □ No

ATTENTION!!! THIS FORM MUST BE SIGNED BY THE REFERRING PHYSICIAN.

Referring physician (print): ____________________________ Office Phone: ____________________________

Physician’s Signature: ____________________________ Date: _____ / _____ / _____ Office Fax: ____________________________

RULE OUT OR CONFIRM THE FOLLOWING

(Please check all that apply)

☐ Sleep Apnea
☐ Narcolepsy/Hypersomnia
☐ Periodic Limb Movement Disorder
☐ Hypoventilation

Has the patient been previously tested in our lab? □ Yes □ No

TYPE OF STUDY REQUESTED

☐ Consultation Only
☐ Nocturnal Polysomnography (NPSG)
☐ Split Night Study
☐ CPAP/BiPAP □ Back-up Rate
☐ MSLT
☐ MWT
☐ Mask Fitting / Desensitization □ PAP / NAP

SPECIAL NEEDS OF PATIENT

☐ Tracheostomy tube
☐ Wheelchair
☐ Home suctioning – trach/nasal/oral
☐ Morbid Obesity
☐ Home oxygen use _________LPM
☐ Does the patient have a feeding tube? □ Yes □ No

Medical Diagnosis: ____________________________________________________________

__________________________________________

Office Fax: ____________________________