SUNY DOWNSTATE Medical Center

SLEEP DISORDERS CENTER
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www.downstate.edu/sleep

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

Gasp or stop breathing during sleep? ❒ Yes ❒ No

Have ADHD? ❒ Yes ❒ No

Have trouble concentrating in school? ❒ Yes ❒ No

Have nightmares/night terrors? ❒ 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
❏ Home suctioning – trach/nasal/oral
❏ Home oxygen use __________LPM
❏ Wheelchair
❏ Morbid Obesity
❏ Does the patient have a feeding tube? ❏ Yes ❏ No

Medical Diagnosis: ____

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