



Pediatric Sleep Referral

860.837.7600 **860.837.5649 fax**
505 Farmington Ave, Farmington, CT. 06032
WWW.CONNECTICUTCHILDRENS.ORG

Patient ID
Connecticut Children's #:
Name:

Patients Name: _____ DOB: _____ Soc. Sec. # : _____

Address: _____
STREET CITY STATE ZIP

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance: _____ ID #: _____

Authorization #: _____ Authorization Expiration : _____

Referring/Attending Physician (Please Print) _____

UPIN # _____

Office Address: _____
STREET CITY STATE ZIP

Office Phone: _____ Office Fax: _____

Study/Service Requested

- Sleep testing ONLY (diagnostic)
- Full Sleep Consultation with testing and management as needed
- Insomnia Evaluation/Behavioral Sleep issues (bedtime problems/nocturnal awakenings)
- CPAP/Bipap titration

Indication for referral (Please check all that may apply):

- Evaluation of possible sleep apnea
- Re-evaluation of sleep apnea after ENT surgery
- Evaluation of sleep-related breathing conditions (other than obstructive sleep apnea) (e.g. in the setting of chronic lung disease, neuromuscular disease, etc.)
- Evaluation of oxygen or BiPAP requirements in patients with documented sleep induced hypoxemia unrelated to obstructive sleep apnea. If at risk for non-obstructive hypoventilation, do you prefer O2 _____, BiPAP _____.
- Evaluation of parasomnias (e.g. sleep walking, sleep talking, sleep terrors, confusional arousals)
- Evaluation of unexplained drowsiness
- Evaluation for narcolepsy (cataplexy, sleep paralysis, hypnogogic imagery with daytime Drowsiness)
- Evaluation of circadian sleep disorders (e.g. delayed sleep phase syndrome)
- Evaluation of restless legs or leg movements in sleep

Pediatric Sleep Referral Con't.

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Sleep History *Does, or has, the patient:*

Wake up with a headache?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Been told that they make kicking movements during sleep?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Have poor school performance?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Snore during sleep?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Have difficulty staying asleep?... <input type="checkbox"/> Yes <input type="checkbox"/> No	Have hyperactivity or is inattentive?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Been observed to have pauses in breathing pattern during sleep?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Have difficulty staying awake during the day?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Had a previous sleep study?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Awaken with gasping, choking, dry mouth or throat?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Feel sleepy or fatigued during the day?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If so, when and where?</i> _____
Tend to be a mouth breather?..... <input type="checkbox"/> Yes <input type="checkbox"/> No		

A typical sleep schedule *Please indicate:* **Bed time:** _____ **Arise time:** _____

Does the patient have a tracheostomy? Yes No, *If YES, during study, should the tracheostomy be:* Open Capped

Does the patient use supplemental oxygen? Yes No, *If YES, _____ L/min*
If YES, should test be initiated on O2? Yes No, *How much?* _____ L/min

Does the patient use CPAP/BiPAP? Yes No, *If YES, what mode, pressure, mask & size?* _____

Special Instructions/Needs: _____

If the patient is non-ambulatory, please explain: _____

Medical History:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Large tonsils	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Gastroesophageal reflux
<input type="checkbox"/> Allergies	<input type="checkbox"/> Large adenoids	<input type="checkbox"/> Nasal obstruction	<input type="checkbox"/> Craniofacial malformation
<input type="checkbox"/> Obesity	<input type="checkbox"/> Previous T&A	<input type="checkbox"/> Enlarged tongue	<input type="checkbox"/> Seizures
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nasal polyps	<input type="checkbox"/> Cardiac problems	<input type="checkbox"/> Small pharyngeal inlet

Other medical History/Allergies: _____

Date & type of serious injury: _____

Medications: _____

Check which of the following are within normal limits. *If abnormal, please describe:*

Nasal passages: *Normal:* _____ *Description:* _____

Oropharynx: *Normal:* _____ *Description:* _____

Neck: *Normal:* _____ *Description:* _____

Chest: *Normal:* _____ *Description:* _____

Abdomen: *Normal:* _____ *Description:* _____

Extremities: *Normal:* _____ *Description:* _____

Neurological: *Normal:* _____ *Description:* _____

Any clinical evidence of tuberculosis? Yes No *If YES, treatment:* _____

MD/Provider's signature: _____ **Date:** _____ **MD/Provider's name (print):** _____