Pediatric Sleep Referral

860.837.6643 **860.837.6658** *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: ______________________

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

Please complete and return both pages (1+2), along with any previous sleep study reports.
We will be happy to contact your patient to schedule their services!

- ☐ Evaluation of possible sleep apnea
- ☐ Re-evaluation of sleep apnea after ENT surgery
- ☐ Annual re-evaluation for pt. on CPAP/BiPAP (begin at: CPAP ______cm, BiPAP ___/___ cm)
- ☐ CPAP or BiPAP titration for patient with documented sleep apnea
- ☐ 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
- ☐ Insomnia evaluation

MD/Referring Provider: ______________________

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Pediatric Sleep Referral Con't.

Patient ID
Connecticut Children's #:

Name:

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

Wake up with a headache? ☐ Yes ☐ No
Snore during sleep? ☐ Yes ☐ No
Been observed to have pauses in breathing pattern during sleep? ☐ Yes ☐ No
Awaken with gasping, choking, dry mouth or throat? ☐ Yes ☐ No
Tend to be a mouth breather? ☐ Yes ☐ No

Been told that they make kicking movements during sleep? ☐ Yes ☐ No
Have difficulty staying asleep? ☐ Yes ☐ No
Have difficulty staying awake during the day? ☐ Yes ☐ No
Feel sleepy or fatigued during the day? ☐ Yes ☐ No

Have poor school performance? ☐ Yes ☐ No
Have hyperactivity or is inattentive? ☐ Yes ☐ No
Had a previous sleep study? ☐ Yes ☐ No
If so, when and where? __________________

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:

☐ Asthma
☐ Allergies
☐ Obesity
☐ Diabetes
☐ Large tonsils
☐ Large adenoids
☐ Previous T&A
☐ Nasal polyps
☐ Muscle weakness
☐ Nasal obstruction
☐ Enlarged tongue
☐ Cardiac problems
☐ Gastroesophageal reflux
☐ Craniofacial malformation
☐ Seizures
☐ Small pharyngeal inlet

Other medical History/Allergies: ____________________

Date & type of serious injury: ____________________

Medications: ____________________

Physical Exam: Blood Pressure _______/_______ Height ________ Weight _________ Age ______

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):*** ____________________

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