REFERRAL/ORDER FORM
PEDIATRIC SLEEP

Phone: 860.837.7600 *Fax:* 860.837.6658
505 Farmington Ave, Farmington, CT. 06032

Connecticut Children's Patient Label
for internal use only

Patient Name: (Last) _____ (First) _____

Street Address: _____

City/State/Zip: _____ **Date of Birth:** _____

Preferred Phone: (Home) _____ (Work) _____ (Cell) _____

Parent/Guardian/DCF: _____ **Preferred Language:** _____

If DCF: (Social Worker name) _____ (Phone) _____

This visit is: ☐ Routine ☐ Semi-urgent (within 2 weeks) **Urgent: Please call Department for urgent appointments.**

Insurance: _____ **ID#** _____

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

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? _____

REFERRING PROVIDER INFORMATION

Referring Provider: _____

Referring Provider: (Phone) _____ (Fax) _____

Patient's Primary Care Physician (if different from referring)**:** _____

Is the family aware of the reason for referral? ☐ Yes ☐ No

_____ Date _____ Time _____

Signature/Credentials of ordering Practitioner (APRN, PA, Non-resident MD or DO)

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	☐ Large tonsils	☐ Muscle weakness
☐ Allergies	☐ Gastroesophageal reflux	
☐ Obesity	☐ Large adenoids	☐ Nasal obstruction
☐ Diabetes	☐ Craniofacial malformation	
☐ Enlarged tongue	☐ Previous T&A	☐ Cardiac problems
	☐ Seizures	
	☐ Nasal polyps	
	☐ 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:* _____