PEDIATRIC SLEEP MEDICINE REFERRAL FORM

Patient's Name: ---------- **DOB:** ____/____/____ **Gender:** ☐ Male ☐ Female

Address: ----------

Home/Cell Phone #: _____ **Parent's Work #** _____

REQUEST:

☐ Polysomnography (please include H&P) ☐ Initial consult (office visit)

Direct referral for polysomnography (overnight sleep test) may be made to rule out sleep apnea in generally healthy children 4 years old, when recent history and physical exam are submitted by referring physician. All others should be referred for office consultation.

MEDICAL HISTORY

Height:	**Weight:**	**Blood pressure:**
CHECK ALL THAT APPLY:		
☐ Adenotonsillar hypertrophy	☐ Craniofacial anomalies	☐ Urological problems
☐ S/P adenoidectomy/tonsillectomy or s/p other airway surgery	☐ Hypotonia	☐ History of brain injury
	☐ Hypertension	☐ Seizures/epilepsy
☐ Frequent congestion/URI's	☐ Failure to thrive	☐ ADHD
☐ Gastroesophageal reflux	☐ Iron-deficiency	☐ Other behavioral/psychiatric problems
☐ Obesity	Other:	

SLEEP HISTORY

☐ Snoring	☐ Restless leg symptoms	☐ Sleepwalking
☐ Gasping/choking during sleep	☐ Twitching/kicking legs during sleep	☐ Teeth-grinding during sleep period
☐ Witnessed apneas during sleep	☐ Difficulty falling/staying asleep	☐ Circadian rhythm problems
☐ Restless sleep	☐ Bedtime resistance	☐ Nocturnal seizures
☐ Sweating during sleep	☐ Sleep terrors	☐ Sleep attacks
☐ Daytime sleepiness	☐ Nightmares	☐ Cataplexy (feels weak with strong emotions)
	☐ Bed wetting	
☐ Hyperactivity/inattention	☐ Head-banging/ body rocking during sleep period	☐ Hallucinations/paralysis upon falling asleep or upon awakening
Other:		

Allergies: _____

Medications: ----------

Special Needs: ☐ Wheelchair ☐ Primary language not English (language spoken: ----------) ☐ Self-injurious behavior

Other Pertinent Information: ----------

Referring Physician: _____ NPI #: _____ Follow-up Visit Date :

Specialty: _____ Phone Number: _____

Address: _____ Fax Number _____