



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: | | |
| <input type="checkbox"/> Adenotonsillar hypertrophy | <input type="checkbox"/> Craniofacial anomalies | <input type="checkbox"/> Urological problems |
| <input type="checkbox"/> S/P adenoidectomy/tonsillectomy or s/p other airway surgery | <input type="checkbox"/> Hypotonia | <input type="checkbox"/> History of brain injury |
| | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Frequent congestion/URI's | <input type="checkbox"/> Failure to thrive | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Gastroesophageal reflux | <input type="checkbox"/> Iron-deficiency | <input type="checkbox"/> Other behavioral/psychiatric problems |
| <input type="checkbox"/> Obesity | Other: _____ | |

SLEEP HISTORY

| | | |
|--|--|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Restless leg symptoms | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Gasping/choking during sleep | <input type="checkbox"/> Twitching/kicking legs during sleep | <input type="checkbox"/> Teeth-grinding during sleep period |
| <input type="checkbox"/> Witnessed apneas during sleep | <input type="checkbox"/> Difficulty falling/staying asleep | <input type="checkbox"/> Circadian rhythm problems |
| <input type="checkbox"/> Restless sleep | <input type="checkbox"/> Bedtime resistance | <input type="checkbox"/> Nocturnal seizures |
| <input type="checkbox"/> Sweating during sleep | <input type="checkbox"/> Sleep terrors | <input type="checkbox"/> Sleep attacks |
| <input type="checkbox"/> Daytime sleepiness | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Cataplexy (feels weak with strong emotions) |
| | <input type="checkbox"/> Bed wetting | |
| <input type="checkbox"/> Hyperactivity/inattention | <input type="checkbox"/> Head-banging/ body rocking during sleep period | <input type="checkbox"/> 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: _____

