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

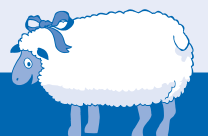
Other Pertinent Information:____

____

Referring Physician:________________________ NPI #:________________ **Follow-up Visit Date:**

Specialty:________________________ Phone Number:________________ ________________

Address:________________________ Fax Number:________________



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