Sleep Diagnostic Laboratory

Phone (914) 493-1105 Fax (914) 493-1501

PEDIATRIC SLEEP STUDY REFERRAL FORM

Patient name:_____
Contact Home Phone:_____
Contact Work/cell Phone:_____
Address:_____
City/ST/ZIP:_____
DOB:_____ **Sex: M / F**

INSURANCE INFORMATION:
INS. CO._____
I.D. #_____ **GROUP #**_____
INS. PHONE:_____
INSURED NAME: _____
PCP: _____ **PCP TEL#:**_____

VERIFICATION OF MEDICAL NECESSITY:

TYPE OF STUDY REQUESTED:
_____Nocturnal polysomnogram (NPSG) 95810
_____CPAP titration for OSA[no $ETCO_2$] 95811
_____BPAP titration for OSA[no $ETCO_2$] 95811
_____BPAP titration for hypoventilation[with $ETCO_2$] 95811
_____Split night study (NPSG/CPAP if AHI ≥20)
_____Multiple Sleep Latency Test (MSLT) 95805

PATIENT REFERRED FOR EVALUATION OF:
_____Obstructive Sleep Apnea 327.23
_____Central Sleep Apnea 327.3
_____Hypoventilation 327.26
_____Unexplained drowsiness 327.10
_____Unspec. Sleep Disturbance 780.50
_____Post-operative evaluation:_____
_____RLS/PLMD 327.51
_____Narcolepsy 347
_____Parasomnias 327.40
_____ Insomnia 327.00
_____Other:_____

SPECIAL INSTRUCTIONS : _____

_____

SLEEP HISTORY: Does, or has, the patient:

Often wake up with a morning headache?_____	YES	NO
Snore regularly/excessively 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
Experience a restless sensation in arms or legs during sleep or in the evening?_____	YES	NO
Been told that they make kicking movements during sleep?_____	YES	NO
Have difficulty falling asleep at the beginning of the night?_____	YES	NO
Have difficulty staying awake during the day?_____	YES	NO
Have sudden loss of strength in arms or legs while awake? (induced by strong emotion)_____	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 (also, please attach prior test results)?_____
How long does it typically take the patient to fall asleep?_____
Usual Bedtime:_____AM/PM Usual wake-up time: _____AM/PM

MEDICAL HISTORY: **(Please also include office visit HISTORY & PHYSICAL)**

_____Asthma	_____Large tonsils	_____Deviated septum	_____Gastroesophogeal Reflux
_____Allergies	_____Large adenoids	_____Nasal obstruction	_____Craniofacial Malformation
_____Obesity	_____Previous T&A?	_____Enlarged Tongue	_____Seizures
_____Cardiac problems	_____Nasal polyps	_____Small pharyngeal inlet	_____Neuromuscular weakness

Other Medical History/Allergies:_____
Does the patient have a tracheostomy? **Y N** If yes, during study should the tracheostomy be **OPEN** or **CAPPED**?
Does the patient use supplemental oxygen? **Y N** If so, should O_2 be given during the test? **Y N** How much? ____L/min?
Does the patient use CPAP or BPAP? **Y N** If so, what mode, pressures, and mask size? _____
Date & type of serious surgery:_____
Has the patient been seen by a Pediatric Pulmonologist on staff at Westchester Medical Center? **Y N**

WEIGHT: _____lb. HEIGHT:_____in. **MEDICATIONS**:_____

I AUTHORIZE SSA TO PERFORM SLEEP STUDIES ON ABOVE PATIENT ACCORDING TO THEIR PROTOCOLS, INCLUDING URGENT INITIATION OF O2 & CPAP.

I request a consultation with a pediatric sleep specialist _before/ _ after sleep study.

PHYSICIAN (Print)**:**_____ **SIGNATURE:**_____**DATE:**_____
SPECIALTY: _____ **PHONE #**_____**FAX #**_____
ADDRESS:_____

****(OFFICE USE ONLY)**** MEDICAL DIRECTOR REVIEW: _____