Children's National Medical Center

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PEDIATRIC SLEEP DISORDERS LABORATORY

SLEEP STUDY REQUEST FORM

Phone: (202) 476-2022 Fax: (202) 476-2981

PATIENT INFORMATION: (may attach demographic sheet)

Name_____ DOB _____ Age _____Y _____M Sex: ☐ M ☐ F
Last First MI

Insurance Carrier and ID # _____ **Must send copy of Insurance card** ☐ Done

Parent's name_____ **Address** _____

Contact Information: Telephone (Home) _____ **(Work)** _____ **(Mobile)** _____ **Email**_____

Referring Physician _____ **Specialty**_____ **Phone #**_____**Fax#**_____

Primary Care Physician _____ **Ph #**_____ **Fax#**_____

Ordering Physician Signature _____ **Date** _____

REASON FOR SLEEP STUDY REFERRAL_____

NOTE: PLEASE ATTACH A COPY OF THE PATIENT'S MOST RECENT CLINICAL ENCOUNTER DOCUMENTING DETAILS OF THE SLEEP HISTORY, PHYSICAL EXAM AND REASON FOR REFERRAL

PRESENTING COMPLAINTS: *(Check all that apply)*

☐ Loud snoring	☐ Cyanosis/hypoxia	☐ On CPAP/BiPAP	☐ Bedtime resistance	☐ Restless legs symptoms
☐ Choking/gasping arousals	☐ ALTE	☐ Daytime sleepiness	☐ Difficulty falling asleep	☐ Sleepwalking
☐ Observed apneas in sleep	☐ Apnea of prematurity	☐ Mood/behavior problems	☐ Night wakings	☐ Sleep terrors
☐ Restless sleep	☐ On O2	☐ Attention problems/ADHD	☐ Insufficient sleep	☐ Circadian rhythm disruption
☐ Nocturnal diaphoresis	☐ On ventilator	☐ Academic concerns	☐ Inadequate sleep hygiene	☐ Nocturnal seizures
☐ Enuresis	☐ Tracheostomy	☐ Other _____	☐ Other _____	☐ Other _____

RISK FACTORS/MEDICAL CONDITIONS: *(Check all that apply):*

☐ Adenotonsillar hypertrophy	☐ Gastroesophageal reflux	☐ Cystic fibrosis
☐ S/P T&A Date_____	☐ Craniofacial anamolies	☐ Prematurity/BPD
☐ Obesity BMI_____	☐ Down syndrome	☐ Tracheostomy
☐ Allergies	☐ Neuromuscular disease/CP	☐ Seizures (type):_____
☐ Asthma	☐ Developmental delay/MR	☐ Other _____
☐ Family history OSA	☐ Sickle cell disease	

Previous sleep studies? ☐ Yes ☐ CNMC lab? ☐ Other lab? (if so, please attach previous sleep study results)

CURRENT MEDICATIONS: _____

POLYSOMNOGRAM REQUESTED: ☐ Elective ☐ Urgent ☐ Pre-op Surgery date _____

☐ **PSG** 95810 ☐ **PSG + CPAP/BiPAP titration (initial)** 95811
☐ **PSG + MSLT** 95810 + 95805 ☐ **PSG + CPAP/BiPAP titration (repeat)** 95811 **Current settings:**_____

☐ **PSG + Seizure montage** 95810
☐ **PSG + Other (Ventilator, O2, Tracheostomy)** 95810 (requires referral by a pediatric pulmonologist)

FOLLOW UP (please check one): ☐ CNMC Sleep Clinic _____ ☐ Referring physician ☐ PCP ☐ Other: _____

SPECIAL INTRUCTIONS: _____

---------- **Area Below For Sleep Laboratory Use Only** ----------

☐ Sleep Study Request reviewed and approved by Judith Owens MD, Medical Director ☐ Not approved ☐ Approval pending

Comments: _____ Signature: _____ Date: _____

Rev 2/23/11