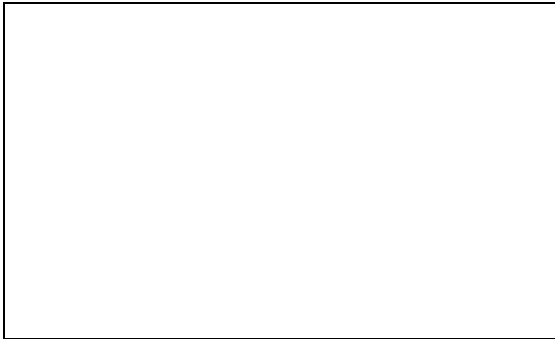




Children's National Medical Center
PEDIATRIC SLEEP DISORDERS LABORATORY
SLEEP STUDY REQUEST FORM
Phone: (202) 476-2022 Fax: (202) 476-2981



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)

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

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

<input type="checkbox"/> Adenotonsillar hypertrophy	<input type="checkbox"/> Gastroesophageal reflux	<input type="checkbox"/> Cystic fibrosis
<input type="checkbox"/> S/P T&A Date _____	<input type="checkbox"/> Craniofacial anomalies	<input type="checkbox"/> Prematurity/BPD
<input type="checkbox"/> Obesity BMI _____	<input type="checkbox"/> Down syndrome	<input type="checkbox"/> Tracheostomy
<input type="checkbox"/> Allergies	<input type="checkbox"/> Neuromuscular disease/CP	<input type="checkbox"/> Seizures (type): _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Developmental delay/MR	<input type="checkbox"/> Other _____
<input type="checkbox"/> Family history OSA	<input type="checkbox"/> 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 (95782 for < 6 yrs. old) PSG + CPAP/BiPAP titration (initial) 95811 (95783 for < 6 yrs. old)
- PSG + MSLT 95810 + 95805 PSG + CPAP/BiPAP titration (repeat) 95811 Current settings: _____
 (or 95782) (or 95783)
- PSG + Seizure montage 95810 or 95782
- PSG + Other (Ventilator, O2, Tracheostomy) 95810 or 95782 (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 Gustavo Nino, MD, Medical Director Not approved Approval pending

Comments: _____ Signature: _____ Date: _____ Rev 3/31/15