



Patient Label or
Patient Name
DOB or MR#

Pediatric Sleep Study Order Set

FAX ALL DOCUMENTS TO:

Surgery & Diagnostic Scheduling

Fax 531-355-0026

Phone 531-355-6737

Today's Date: _____

Referring Provider: _____ Phone: _____

Provider Specialty: _____ Fax: _____

Thank you for referring your patient to the Sleep Disorders Center. Please fax the following information so we can provide the best and most timely service:

- Insurance and Demographic information
- Most recent H & P and/or clinic note on the patient you are referring

Patient Name: _____ Date of Birth: _____ Phone: _____

Parent/Guardian Name: _____

Pediatric Sleep Study Requested:

Diagnostic Sleep Study Comments: _____

Has patient had prior tonsil/adenoid surgery? Yes No

If yes: Tonsillectomy Adenoidectomy Adenotonsillectomy

Date of Surgery (month/year) _____

Comments: _____

Current Diagnoses (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Choking / Gaspings |
| <input type="checkbox"/> Morning headaches | <input type="checkbox"/> Central Sleep Apnea | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Hypoventilation | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Witnessed Apnea | <input type="checkbox"/> Hypoxemia | <input type="checkbox"/> Craniofacial Abnormalities |
| <input type="checkbox"/> Daytime sleepiness | <input type="checkbox"/> Seizures | <input type="checkbox"/> Neuromuscular Disease |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Periodic Limb Movements | <input type="checkbox"/> Autism Spectrum Disorder |
| <input type="checkbox"/> Parasomnia | <input type="checkbox"/> Restless Leg Syndrome | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Tonsillar Hypertrophy | <input type="checkbox"/> Obesity | |
| <input type="checkbox"/> Adenoid Hypertrophy | <input type="checkbox"/> Other: _____ | |

Provider Signature: _____ Date: _____ Time: _____