SLCH/WUSM SLEEP DIAGNOSTIC SERVICE, 1 Children's Place, St. Louis, MO 63110
Ph.: (314) 454-4503; Fax: (314) 454-4266

PHYSICIAN REFERRAL FOR SLEEP STUDY

The American Academy of Sleep Medicine requires that we have the information below in each patient's chart. Please fax the completed form along with the most *recent history and physical* and a *copy of the patient's insurance card* to the Sleep Diagnostic Service at St. Louis Children's Hospital.

If you are requesting a sleep study, we will request an insurance authorization from your office.

Our fax number is 314-454-4266. If you have any questions, the phone number of the SLCH Sleep Diagnostic Lab is 314-454-4503. Thank You.

Today's date_______________ **Appointment Date: __________________**

Services Requesting:

_______Consult with Sleep Specialist **______Sleep Study**

****_PLEASE NOTE_** IF YOU ARE REQUESTING A CONSULT AND A SLEEP STUDY FOR YOUR PATIENT, PLEASE MARK HERE IF THE PATIENT IS ALLOWED TO HAVE THE SLEEP STUDY *BEFORE* OR *AFTER* THE PATIENT IS SCHEDULED FOR A CONSULT WITH A SLEEP SPECIALIST**. *FAILURE TO MARK THESE OPTIONS WILL LEAD TO DELAYS IN SCHEDULING.*

____________ I attest that the patient has my approval to schedule the Sleep Study *BEFORE* the Consult is scheduled with the Sleep Specialist.
____________ I attest that the patient has my approval to schedule the Sleep Study *AFTER* Consult with the Sleep Specialist.

Patient Information

Name: __________________________________ **DOB: _________________________**

Weight: _________________________ KG / LB **Height: ________________CM / IN**

Parent's Name: ____

Address: ____

____

Home Phone: __________________________ **Cell Phone: _______________________**

Insurance: ____

Sleep Problems

__ Excessive Daytime sleepiness
__ Snoring
__ Frequent Awakenings
__ Leg Movements
__ Night Terrors
__ OSAS
__ Can't go to sleep or stay asleep
__Morning Headaches
__Witnessed Apnea
__Insomnia
__Bedwetting
__Sleep Walking
__CPAP/BiPAP

Medical Conditions

__ None
__ Cardiac Arrhythmias
__ Achondroplasia/Dwarfism
__ Bronchopulmonary dysplasia (BPD)
__ Cerebral Palsy
__ Spina Bifida
__ Attention Deficit Disorder
__Muscular Weakness
__Asthma
__Reflux
__Down Syndrome
__Sickle Cell Anemia
__Nasal/sinus allergies
__Seizures
__ Treacher-Collins, Pierre Robin, or Prader-Willi Syndrome
__ Obesity
__ Other ____

HEENT

Tonsils: ____Removed **Date of Surgery: _________________**

____Intact **_____Enlarged**

Adenoids: ____Removed **Date of Surgery: _________________**

____Intact **____Enlarged**

Current Medication

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

Special Care Needs:

Does child require respiratory assist devices or noninvasive ventilator support (i.e. continuous or bilevel positive pressure support) at night?

YES _____ NO _____

Other special care needs?

____

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____

____

Comments:____

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Referring Physician Information

Requesting Physician: ____

Phone: ________________________________ **Fax:** ______________________________

Physician's Signature: ____

Date: _________________________________

Thank You