SLCH/WUSM SLEEP DIAGNOSTIC SERVICE (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.

Please note that Washington University's board certified pediatric sleep medicine physicians conduct sleep studies in two locations, at St. Louis Children's Hospital, and at WU's outpatient office in Brentwood, MO (Center 40). Depending on the child's needs and medical history, their appointment may be scheduled at either location. We will contact the parents to set an appointment date and inform them of the location of their study.

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**

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**
__ **Treacher-Collins, Pierre Robin, or Prader-Willi Syndrome**
__ **Obesity**
__ **Other**_____
__**Muscular Weakness**
__**Asthma**
__**Reflux**
__**Down Syndrome**
__**Sickle Cell Anemia**
__**Nasal/sinus allergies**
__**Seizures**

HEENT

Tonsils: ____Removed **Date of Surgery: _____**

____Present **_____Enlarged**

Adenoids ____Removed **Date of Surgery:_____**

____Present **____Enlarged**

Current Medication

_____ _____

_____ _____

Special Care Needs:

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

YES___ NO___

Other special care needs?

_____

_____

_____

Comments:_____

_____

_____

_____

Referring Physician Information

Requesting Physician:_____

Phone:_____ **Fax:**_____

Physician's Signature:_____

Date:_____

Thank You