Emerald Coast Pediatric

Sleep Consultants, LLC

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# DIRECT REFERRAL FOR SLEEP STUDY

Please complete this form and submit for review a current history and physical on the patient. After review of the information and approval of the requested sleep study by a sleep staff physician, the patient will be called to schedule a sleep study.

## Personal Information

Patient's Name: ______________________________ Date of Birth: ___________

Home Phone : ______________________ Work Phone: ___________________

Cell Phone: ______________________ Gender: M F

## Provider Information

Referring Provider:

Street Address: _______________________

_______________________________________

Suite: ________________________________

City: ________________________________

State: ________________________________

Zip: ________________________________

Office Phone: ______________________________

Office Fax: ______________________________

Provider Email: _______________________

Primary Care Provider:

Name: ________________________________

Office Phone: ______________________________

Office Fax: ______________________________

## Type of Study Requested (check all that apply)

_____ Polysomnogram

_____ Polysomnogram with MSLT (evaluate daytime somnolence/narcolepsy)

_____ PAP titration (continuous or bilevel)

_____ PAP Nap (to help patients become accustomed to the PAP device prior to titration study)

_____ End Tidal CO2 Monitoring

**Reason for Sleep Study** (Check all that apply)

| | | | |
|---|---|---|---|
| ______ | Suspected sleep apnea | ______ | Restless sleep |
| ______ | Daytime Somnolence | ______ | Restless Legs |
| ______ | Sleepwalking/Talking | ______ | Nightmares/Night Terrors |
| ______ | Snoring | ______ | Insomnia |
| ______ | Night awakenings | ______ | Seizures |
| ______ | Behavior problems/ADHD | ______ | Headaches |
| ______ | Obesity | ______ | Other__________________________ |

**Underlying Medical Conditions**

1.
2.
3.
4.
5.
6.

**Technology-Dependence** (Check all that apply)

| | | | |
|---|---|---|---|
| ______ | Tracheostomy | ______ | Home ventilator* |
| ______ | G-tube | ______ | Oxygen** |
| ______ | Catheterization | ______ | IV therapy |

Home vent settings*:

Oxygen requirements**:

**Other Special Needs** (Check all that apply)

______ Requires assistance moving
______ Requires assistance with personal hygiene
______ Hearing Impairment (will require a translator over the age of 18 for sign language to be present if needed)
______ Vision Impairment (please indicate if canine assistance will be present)
______ Language barrier (will require a translator over the age of 18 to be present if needed)
______ Other

**Ordering Provider Signature**
(By signing below, you also give CNC Sleep staff permission to administer oxygen to the above patient per protocol if needed.)

_______________________________________________ Date: ____________________

**Approval by Medical Director or Designated Sleep Staff Provider**

_______________________________________________ Date: ____________________