PennState Health

**Sleep Research and Treatment Center**
1214 Research Boulevard, Suite 1159
Hummelstown, PA 17036
Phone: 717-531-8520
Fax: 717-312-3135

# PEDIATRIC SLEEP REFERRAL

**All Information must be completed prior to Sleep Review/Scheduling**

## SECTION A

Date: ______________ Patient Name: ______________________________ DOB: __________

Address: ____________________________________________________________

____________________________________________________________ Zip Code: ______________

Phone: ______________________________

**(Or attach patient's current demographics face sheet)**

Diagnosis: ____________________________________________________________

**(Please attach relevant referring physician clinical notes for Pediatric Sleep Specialist Review – patient cannot be scheduled without current documentation)**

Insurance: ______________________________ Subscriber: ______________ ID #: __________

**(Or attach copy of both sides of subscriber insurance card)**

## SECTION B

### REFERRING CLINICIAN TO COMPLETE AND MEDICAL ORDERS

**Medical History:**

- ☐ Premature birth
- ☐ History of ICU monitoring
- ☐ Neurological disorder
- ☐ Recurrent otitis or strep
- ☐ ADHD
- ☐ Obesity
- ☐ Development delay
- ☐ Autism
- ☐ Epilepsy
- ☐ Tonsillar hypertrophy
- ☐ Adenoid hypertrophy
- ☐ Other – Please Specify:

**Presenting Symptoms:**

- ☐ Preliminary Diagnosis: Obstructive Sleep Apnea (G47.33)
- ☐ Snoring
- ☐ Witnessed apneas
- ☐ Gasping or choking during sleep
- ☐ Mouth breathing
- ☐ Nocturnal enuresis
- ☐ Oxygen desaturations
- ☐ Hypertension
- ☐ Daytime sleepiness/Non-Restorative Sleep
- ☐ Insomnia (difficulties falling asleep or staying asleep)
- ☐ Restless legs syndrome
- ☐ Limb twitches
- ☐ Restless sleep
- ☐ Sleep-related bruxism
- ☐ Sleepwalking
- ☐ Night terrors
- ☐ Irritability or mood disturbances
- ☐ Inattention, hyperactivity
- ☐ Other:

**Medical Orders:**
**Please choose one option:**

- ☐ **Diagnostic sleep study and interpretation only.** I will follow up with my patient regarding results and/or treatment.
- ☐ **Diagnostic sleep study** (polysomnogram) AND **new patient consultation** and therapy program after sleep study
- ☐ **Consultation only** with a pediatric sleep specialist (no sleep study)

______________________ ______________
*Print Provider Name* *Date*

______________________
*Provider Signature*

## SECTION C

### Did you remember the following information?

**This is vital for insurance verification and pre-certification.**

- ☐ Patient Demographics
- ☐ Copy of patient's insurance card
- ☐ Office/medical notes documenting **medical necessity of sleep consultation and/or sleep study**
- ☐ Lab Work
- ☐ Previous Sleep Study and CPAP Titration Results
- ☐ Previous Sleep Clinic Notes (if relevant)
- ☐ If an insurance referral is required, please attach the approved referral to this order when faxing.

## TO BE COMPLETED BY PEDIATRIC SLEEP SPECIALIST AFTER REVIEW:

- ☐ Diagnostic Polysomnography (PSG) only
- ☐ Diagnostic PSG, followed by new patient consultation with:______________________________
- ☐ Consult only, with: ________________________________________

Additional Information for Study:

____________________________________________________

____________________________________________________

____________________________________________________

Review completed by: ________________________ Date/Time: ________________

Special Needs for Overnight Visit (Check all that apply):

- ☐ Wheelchair/Walker
- ☐ Skilled parent or nurse must accompany
- ☐ Home O2 _______L/min
- ☐ Hair products/pieces
- ☐ Interpreter needed
- ☐ Other: ________________________
- ☐ Patient: tech ratio:
- ☐ Crib

Appointment Date: ______________________ Appointment Time: ________________