Children's MINNESOTA

Children's Sleep Center
Sleep Study Request Form

Fax completed form to: 651-220-6443

****FOR EXTERNAL PROVIDER USE ONLY****
Internal provider MUST use electronic Sleep Center Referral

WHEN?	Routine
(Circle One)	Next Available
	ASAP

** **If you need this performed ASAP, please contact our Sleep Lab to accommodate your request at 651-220-6256.**

Is this a follow up Sleep Study? ☐ NO ☐ YES

*****Please note, SNORING MUST be documented for insurance to cover testing*****
Exceptions to this are a dx of Down syndrome, Prader-Willi, etc.
Polysomnogram (PSG) (CPT – 95810)

What is measured? EEG sleep states, HR, ECG, chest & abdominal wall movement, airflow, O2 sat, CO2, body position, chin & leg EMG, eye movements.

PATIENT NAME: _____ **DOB:**_____/_____/_____**AGE** _____

ALLERGIES: (required) _____

Parent/Guardian Contact:_____Phone #:_____Alt. #: _____

ORDERING (MD/NP/PA): (Legible Please)_____**Specialty:** PEDS/FP PULMONARY ENT NEUROLOGY OTHER: _____

Name of Clinic:_____ Location : _____

Clinic Phone #:_____ *****Please include patient demographics and most recent History & Physical***

MEDICAL PROBLEMS JUSTIFYING NEED (Please Check or Circle):

☐ Snoring (more than 3 nights a week)	☐ ADHD / ADD	☐ Labored breathing during sleep
☐ Behavioral problems	☐ Witnessed apnea Gasping episodes	☐ Learning problems
☐ Bedwetting – Secondary, no primary	☐ Adenoid Facies	☐ Sitting upright to sleep / neck hyperextension asleep
☐ Cleft Palate or Craniofacial abnormality	☐ Blue Spells / Cyanosis	☐ High arched palate
☐ Headaches *upon awakening*	☐ Failure to thrive	☐ Daytime sleepiness (consider Sleep Clinic First)
☐ Obesity (BMI _____)	☐ Trisomy 21/ other _____	☐ Asthma / RAD
☐ Adenotonsillar hypertrophy	☐ Neuromuscular disorder: Type: _____	

PERTINENT HISTORY AND PHYSICAL FINDINGS: (Please attach current clinical note)

History of: ☐ Allergic Rhinitis ☐ Nasal Congestion (Please consider treating first) ☐ T & A

CURRENT USE OF OXYGEN: ☐ NO ☐ Yes Amount:_____lpm ☐ Nighttime only

CURRENT PAP SETTINGS: ☐ None ☐ Settings _____

WHAT QUESTION IS TO BE ANSWERED BY THIS TEST?
In order to better meet your needs, what is the **specific question** you would like answered with this sleep study?

_____

_____

Other concerns to be addressed:

☐ Restless sleep	☐ Oxygen status at night / ability to wean oxygen	☐ Periodic Breathing
☐ OSA / Need PAP therapy?	☐ Central Apnea	☐ Insomnia

☐ Periodic Limb Movement Disorder / Restless Legs ☐ Seizures **(Consider adding a FORMAL SEIZURE MONTAGE EEG if this information is desired)**

☐ Other: _____

* S C A N O R D E R *

Thank you for referring to Children's Sleep Center. If you have any questions, contact us:
Sleep Lab: 651-220-6256 Sleep Clinic: 651-220-6258 childrensmn.org