

**Internal provider MUST use electronic Sleep Center Referral**

<b>WHEN?</b>	Routine
(Circle One)	Next Available
	ASAP

**\*\* If you need this performed ASAP, please contact our Sleep Lab to accommodate your request.**

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):**

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Restless sleep                                  | <input type="checkbox"/> Oxygen status at night / ability to wean oxygen  | <input type="checkbox"/> Periodic Breathing |
| <input type="checkbox"/> OSA / Need PAP therapy?                         | <input type="checkbox"/> Central Apnea  | <input type="checkbox"/> Insomnia           |
| <input type="checkbox"/> Periodic Limb Movement Disorder / Restless Legs | <input type="checkbox"/> Seizures (Consider adding a FORMAL SEIZURE MONTAGE EEG if this information is desired) |   |
| <input type="checkbox"/> Other: _____                                    |   |   |



*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](http://childrensmn.org)*