Pediatric Neurology Center
Sleep Studies

children's Hospital at Erlanger

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.

Please fax the completed form to 423-778-8659

PERSONAL INFORMATION

Patient Name: ______________________ Date of Birth: __________

Home Phone: ______________ Work Phone: ______________

Cell Phone: ______________ Gender: M F

REFERRING PROVIDER INFORMATION

Street Address: ______________________ Suite: __________

City: ______________ State: __________ Zip: __________

Office Phone: ______________ Office Fax: ______________

Provider Email: ______________________

PRIMARY CARE PROVIDER

Name: ______________________

Office Phone: ______________ Office Fax: ______________

REASON FOR SLEEP STUDY (Check all that apply)

- ☐ Suspected sleep apnea
- ☐ Daytime somnolence
- ☐ Sleepwalking/talking
- ☐ Snoring
- ☐ Night awakenings
- ☐ Behavior problems/ADHD
- ☐ Obesity
- ☐ Restless sleep
- ☐ Restless legs
- ☐ Nightmares/night terrors
- ☐ Insomnia
- ☐ Seizures
- ☐ Headaches
- ☐ Other ______________

UNDERLYING MEDICAL CONDITIONS

1. ______________________
2. ______________________
3. ______________________
4. ______________________

TECHNOLOGY-DEPENDENCE (Check all that apply)

- ☐ Tracheostomy
- ☐ G-tube
- ☐ Catheterization
- ☐ Home ventilator*
- ☐ Oxygen**
- ☐ 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: ______________

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