SLEEP DISORDERS REFERRAL FORM

Please fill out this form COMPLETELY AND SUBMIT A CURRENT HISTORY AND PHYSICAL OR MOST RECENT OFFICE VISIT on the patient in order to expedite prompt scheduling of your patient. Please fax to **614-722-4000**. After review of the information by a sleep staff physician or nurse practitioner, the patient will be called to schedule a sleep study and/ or clinic visit. Sleep Disorder Center Phone # 614-722-4613

PERSONAL INFORMATION

Patient's Name:_____ MR# _____

Address: _____ Home Phone: _____

City, State, Zip:_____ Gender: _____DOB: _____RACE:_____

Mom's Name: _____ Dad's Name: _____

Work Phone: _____ Work Phone: _____

Sleeping Hours: Bedtime: _____ Awake time: _____

Referring Physician: _____ Phone: _____ Fax: _____

Address: _____

Contact Person:_____ Phone:_____

Primary Physician: _____ Phone: _____ Fax:_____

INSURANCE INFORMATION

Health Insurance Co: _____ Phone#_____

ID#_____ Group#_____

PERTINENT HISTORY AND PHYSICAL INFORMATION

Height _____cm Weight _____kg BMI _____ Allergies _____

➢ ***History of Sleep Problem*:**

☐ Snoring ☐ Apnea ☐ Choking ☐ Coughing ☐ Gasping ☐ Morning Headaches
☐ Frequent Awakenings during sleep ☐ Daytime sleepiness/ fatigue ☐ Falling asleep during the day
☐ R/O Nocturnal seizures ☐ Restless sleep ☐ Nocturnal enuresis ☐ Night terrors
☐ Parasomnias ☐ Sleepwalking ☐ Insomnia ☐ Nocturnal oxygen desaturation
☐ Study with trach capped ☐ Study with: pH probe / impedance
☐ Other:_____
_____

➢ ***Medical Conditions:***

☐ **No medical problems** ☐ ADD/ ADHD ☐ Allergies ☐ Asthma ☐ Autism
☐ Behavior problems ☐ GERD ☐ Cardiac problems ☐ Chronic lung disease ☐ CF
☐ CP ☐ Diabetes: Type_____ ☐ Down's syndrome ☐ MR/DD ☐ Obesity ☐ Seizures
☐ Other_____
☐ **Has G-tube** ☐ **Has Trach** (kind, size_____)

***** Previous T&A?** ☐ yes ☐ no **Other surgeries and hospitalizations:** _____
_____

Has the patient had a previous sleep study or EEG at Nationwide Children's? ☐ yes ☐ no
Will the patient be hospitalized in the near future for a procedure? ☐ yes ☐ no If yes, what?_____
_____

Medications (please list or check no meds) ☐ **No medications**

Medication	Dose	Frequency	Route

HME: (Oxygen, Vent, Feeding pump, CPAP/ BIPAP, etc. → please list below or check none) ☐ **None**

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

Dear Provider,

Thank you for referring your patient to the Sleep Disorders Center.

Please submit the completed sleep referral form along with the following:

- Recent H&P (including vitals & physical examination)
- Last office notes

Once the referral has been triaged by our nurses, we will contact the family to arrange an appointment.

If you have any questions or concerns, please contact the Sleep Lab at 614-722-4613.

Respectfully,

Kimberly Gainer
Business Office Coordinator
Nationwide Children's Hospital
Sleep Disorders Center
614-722-8808