Delivery Network/Location

NAME:

BIRTH DATE:

MRN:

DOS:

(If handwritten, patient name, MRN, birth date, and DOS)

Yale New Haven Health
Yale New Haven Children's Hospital

Pediatric Sleep Center Referral

Phone: **203-688-1240** Fax: **203-688-8952**

20 York Street, SP 7-440, New Haven, CT 06510 • email: YNHCHSleepCenter@ynhh.org
267 Grant Street 6th floor East Tower - Bridgeport Hospital, Bridgeport, CT 06062
5 Perryridge Road, Greenwich Hospital, Greenwich, CT 06830

Please call the lab or email if you have an urgent request

Failure to fill out form completely will delay your patient's care

Patient's Name: _____ DOB: _____

Address: _____
STREET CITY STATE ZIP

Home: _____ Mobile: _____ Work: _____

Insurance: _____ ID#: _____

Referring Physician (PLEASE PRINT): _____

Office Address: _____
STREET CITY STATE ZIP

Office Phone: _____ Office Fax: _____

REQUESTED PROCEDURE: Please complete and fax both pages. Our staff will schedule your patient

☐ Overnight polysomnogram (to evaluate for obstructive sleep apnea, problems with oxygen or CO2, or other disorders of sleep fragmentation)

***Results will be sent to referring provider.**

☐ Overnight titration for CPAP/BiPAP (for patients with known sleep disordered breathing) with follow up consultation in CPAP Clinic for management of therapy by Sleep Center physician

☐ Overnight polysomnogram plus multiple sleep latency testing (for narcolepsy and other disorders of increased sleep drive)

☐ **Consultation** with physician in **Sleep Clinic <u>only</u> fax** this form to **203-737-7635** (PLEASE CHECK):

☐ **INSOMNIA** ☐ **NIGHT WAKENINGS** ☐ **EXCESSIVE DAYTIME SLEEPINESS** ☐ **RESTLESS LEG SYNDROME**

OTHER _____

_____

_____

Previous Sleep Study? ☐ YES ☐ NO When and Where? _____

Current Oxygen Use? ☐ YES ☐ NO LPM: ____

Current CPAP/BiPAP Use? ☐ YES ☐ NO Current Settings (if available)? _____

Special Instruction/Needs (PLEASE CIRCLE): **AUTISM** **WHEELCHAIR** **DEVELOPMENTAL DELAY** **LANGUAGE BARRIER**

OTHER _____

_____

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MEDICAL HISTORY: check all that apply: REQUIRED

☐ Asthma Allergies	☐ Obesity	☐ Enuresis	☐ Gastroesophageal Reflux
☐ ADHD/ADD	☐ Poor School Performance	☐ Trisomy 21	☐ Neuromuscular Disease Seizures
☐ Hypotonia	☐ Developmental Delay	☐ Cerebral Palsy	☐ Prematurity
☐ Cardiac Defect	☐ Cleft lip/palate	☐ Pierre-Robin	☐ Other chromosomal abnormality
☐ Narcolepsy	☐ BPD/Chronic Lung Disease	☐ Supplemental O2	☐ Tracheostomy
☐ Technology/Ventilator Dependent		☐ Autism	

OTHER _____

_____

MEDICATIONS: _____

_____

_____

HEIGHT: _____ **WEIGHT:** _____

Time	Date	Provider's Signature	Provider's Printed Name
_____	_____	_____	_____

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