Illinois Neurological Institute Sleep Center Physician's Referral Form

Infants and Children (<18 yrs)

Section 1

Patient's Name______________________________ Parent(s) Names ______________________
**Guardian's Name (if applicable) ______________________________
**Caseworker or Agency Name and Phone Number (if applicable)______________________________
Patient's Address______________________________
Date of Birth______________ Work ph#______________________
Home ph#______________________ Mobile/other ph#______________________
Who is this patient's insurance carrier? ______________________________
(If patient has OSF Healthplans, no appointments will be scheduled until we receive their referral)

***Reason for referral** (please be specific):______________________________

**NOTE: A signed "Consent for Treatment" is required for the child to be seen
!! If you want an office consultation before testing need is determined, go to Section 3 (skip Section 2).

Section 2 (for patients referred for testing before or without office consultation)

(Unless the referring physician requests testing only, children referred for reasons other than apnea or apparent life threatening events (ALTE's) will be seen in the office by a sleep specialist in addition to testing. Treatment (such as CPAP) will not be prescribed unless the patient is to see the sleep specialist.

Check here if testing only___________

Please check each that applies:

________ Apparent life threatening event (ALTE) (describe:______________________________)
________ Suspect apnea of prematurity or apnea of infancy
________ Snoring
________ Stopping breathing in sleep (witnessed apnea)
________ Excessive sleepiness
________ Fatigue
________ Inability to move just before sleep or after waking (sleep paralysis)
________ Dreams just before sleep or after waking (hypnogogic hallucinations)
________ Unusual or unwanted behavior in sleep (*briefly describe*______________________________
____
______________________________)
________ Restlessness in legs that keeps him/her awake
________ Difficulty falling asleep or staying asleep
________ Kicking in sleep
________ Sudden weakness when laughing or angry (cataplexy)

	Circle any that apply	
Do you suspect this patient may have sleep apnea?	Yes	No
Do you suspect this patient may have narcolepsy?	Yes	No
Do you suspect sleep terrors or sleepwalking?	Yes	No
Do you suspect this patient may have restless legs syndrome?	Yes	No
Do you suspect this patient may have periodic leg movements in sleep?	Yes	No
Is insomnia a significant problem for this patient?	Yes	No

Medical History: (circle all that apply) HTN Asthma ADD/ADHD Depression Diabetes
Please note any other significant medical history: ______________________________
Physical Exam: Height__________ Weight__________ Neck circumference ______________
large uvula Y / N crowded oropharynx Y / N retrognathia or micrognathia Y / N

Please note any abnormalities of the following: tongue, nasal passages, dentition, maxilla or mandible______________________________
____

Is this patient on supplemental **oxygen** therapy? Yes No If yes, how much?_______ Why? ______________
When is used? _______daytime only _______ nighttime only _______ 24 hrs _______ PRN
If sleep apnea is found during a polysomnogram, may we initiate **CPAP** treatment in a split night study? Yes No
Does the patient have any disability that would require extra assistance during a sleep study? Yes No

Section 3

Office Location and Fax Number for this Patient's Correspondence:______________________________

Ordering Physician's Signature______________________________

Print resident's name______________________ **Print attending's name** ______________________

Ordering Physician's phone # ______________________ **Today's Date**______________________
fax to 655-6967

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