

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# _____

Email address: _____

Who is this patient's insurance carrier? _____

(If patient has Humana Insurance, 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 | _____ Restlessness in legs that keeps him/her awake |
| _____ Snoring | _____ Difficulty falling asleep or staying asleep |
| _____ Stopping breathing in sleep (witnessed apnea) | _____ Kicking in sleep |
| _____ Excessive sleepiness | _____ Sudden weakness when laughing or angry (cataplexy) |
| _____ Fatigue | |
| _____ Inability to move just before sleep or after waking (sleep paralysis) | |
| _____ Dreams just before sleep or after waking (hypnagogic hallucinations) | |
| _____ Unusual or unwanted behavior in sleep (<i>briefly describe</i> _____) | |

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