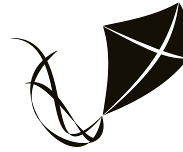
Randall Children's Hospital Sleep Center



2801 N. Gantenbein Ave., Suite 3121
Portland, OR 97227
Phone: 503-413-5240
Fax: 503-413-3621

Pediatric sleep study order form

Patient name: ______________________ Ordering physician: ______________________

Address: ______________________ Phone: ______________________

Daytime phone: ______________________ Fax: ______________________

Date of birth: ______________________ Address: ______________________

Patient insurance: ______________________

Insurance preauthorization #: ______________________

Items **required** to be sent with order:
- ☐ Insurance information
- ☐ Demographics sheet
- ☐ History and physical
- ☐ Medication list
- ☐ Previous sleep studies/results (if applicable)

Indications for study

- ☐ Snoring
- ☐ Hypercarbia
- ☐ Parasomnia
- ☐ Narcolepsy
- ☐ Observed apnea
- ☐ Insomnia
- ☐ Nocturnal movement
- ☐ Excessive daytime sleepiness
- ☐ Other. Please specify: ______________________

Order selection

☐ Sleep physician consultation: ***Includes sleep evaluation, sleep study if indicated, treatment and follow-up***

☐ Routine **diagnostic only** study (no CPAP)
☐ Routine split-night study (if criteria met, CPAP will be initiated)
☐ CPAP/BIPAP titration (prior diagnostic study required)
☐ BILEVEL titration (prior diagnostic study required) Previously failed CPAP? ○ Yes ○ No

The following procedures require consultation with a sleep specialist prior to scheduling:
☐ MSLT ☐ MWT ☐ Parasomnia evaluation ☐ ASV titration ☐ AVAPS tiration

Oxygen administration

☐ Administered oxygen per sleep center protocol ☐ Patient currently on home O2 at __________.
☐ Adjust O2 to maintain SPO2 between __________ and __________%
CO2 is monitored on all pediatric patients

Special instructions

Does the patient require an interpreter? ○ No ○ Yes if yes, what language? ______________________

Dose the patient have any special needs? (wheelchair, incontinence, etc.)
If yes, please describe: ______________________

Physician signature: ______________________ Date: ______________________

Reviewed by Medical Director: ______________________

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