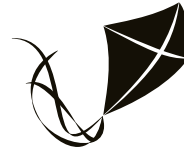


Randall Children's Sleep Medicine

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**RANDALL CHILDREN'S
HOSPITAL**
LEGACY EMANUEL

Pediatric sleep study order form

Patient name: _____ Ordering physician: _____
Address: _____ Phone: _____
Daytime phone: _____ Fax: _____
Date of birth: _____ Address: _____
Patient insurance: _____ Items **required** to be sent with order:
Insurance preauthorization #: _____
 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 titration

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

Physician signature: _____ Date: _____

Reviewed by Medical Director: _____