Randall Children's Sleep Medicine

501 N. Graham St., Suite 330A
Portland, OR 97227
Phone: 503-413-5240
Fax: 503-413-3621

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: _____

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: _____