BOYS TOWN National Research Hospital

Patient Label or
Patient Name
DOB or MR#

Pediatric Sleep Study Order Set

FAX ALL DOCUMENTS TO:
Outpatient Diagnostic Scheduling
Fax 531-355-0026
Phone 531-355-6737

Today's Date: _____

Referring Provider: _____ Phone: _____

Provider Specialty: _____ Fax: _____

Thank you for referring your patient to the Sleep Disorders Center. Please fax the following information so we can provide the best and most timely service:

- Insurance and Demographic information
- Most recent H &P and/or clinic note on the patient you are referring

Patient Name: _____ Date of Birth: _____ Phone: _____
Parent/Guardian Name: _____

Pediatric Sleep Study Requested:

☐ Diagnostic Sleep Study Comments: _____

Has patient had prior tonsil/adenoid surgery? ☐ Yes ☐ No
If yes: ☐ Tonsillectomy ☐ Adenoidectomy ☐ Adenotonsillectomy
Date of Surgery (month/year) _____
Comments: _____

Current Diagnoses (check all that apply):

☐ Snoring	☐ Obstructive Sleep Apnea	☐ Choking / Gasping
☐ Morning headaches	☐ Central Sleep Apnea	☐ ADHD
☐ Sleep Disturbance	☐ Hypoventilation	☐ Down Syndrome
☐ Witnessed Apnea	☐ Hypoxemia	☐ Craniofacial Abnormalities
☐ Daytime sleepiness	☐ Seizures	☐ Neuromuscular Disease
☐ Insomnia	☐ Periodic Limb Movements	☐ Autism Spectrum Disorder
☐ Parasomnia	☐ Restless Leg Syndrome	☐ Sickle Cell Disease
☐ Tonsillar Hypertrophy	☐ Obesity	
☐ Adenoid Hypertrophy	☐ Other: _____	

Provider Signature: _____ Date: _____ Time: _____