THE University of Vermont MEDICAL CENTER

UVM Medical Center Sleep Program
1 South Prospect Street
Phone: (802) 847-5338/ Fax: (802) 847-0379

Name:

DOB:

PEDIATRIC Sleep Medicine Order Form

Please check only one box:

☐ **Pediatric Ambulatory Sleep Consult** (Medical Provider) PSG will be ordered as deemed necessary

☐ **Pediatric Ambulatory Insomnia / Behavioral Sleep Consult** (Licensed Psychologist)

☐ **Pediatric Overnight Diagnostic Polysomnogram (PSG)**
The Ordering Provider of PSGs must be from PediENT, PediNeuro, PediPulm or Sleep Medicine
Additional Montage Required? Full Head EEG___; RBD___; RBD w/Full Head___; NMD___; TcC02___
Additional Daytime Testing Required? MSLT ___; MWT___
Would you like an Ambulatory Sleep Consult after Study is performed? __ Yes

☐ **Pediatric Overnight CPAP/BiPAP Titration Polysomnogram (Titration)** *(see next page)
The Ordering Provider of Titration must be from PediPulm or Sleep Medicine
Polysomnogram Diagnosis of OSA: Year_______ Location___________________________________
(If performed outside of UVMMC, please send copy of report with referral form)

IMPORTANT regarding Polysomnograms
The results of the study are sent to the Ordering Provider, who is responsible for conveying the results to the patient and determining care.

Please circle yes or no:

Symptoms:

Yes / No Noisy Breathing / Snoring
Yes / No Apneas / Pauses
Yes / No Restless Sleep
Yes / No Frequent Awakenings
Yes / No Unusual Behavior during Sleep
Yes / No RLS / Leg Movements
Yes / No Insomnia
Yes / No Reduced Daytime Functioning
Yes / No Hypersomnolence
Yes / No Hyperactivity / Behavioral Concerns

Problem List:

Yes / No Chronic Nasal Congestion
Yes / No Large Tonsils
Yes / No Autism Spectrum
Yes / No Down Syndrome
Yes / No Neuromuscular Disease
Yes / No Seizure Disorder
Yes / No Airway Malacia
Yes / No Craniofacial Disorder
Yes / No Cystic Fibrosis
Yes / No GERD
Yes / No Nocturnal Hypoxemia
Yes / No Hypercapneic Respiratory Failure

SAFETY (In order to help ensure proper study location and level of assistance)

Yes / No Request Hospital Setting
Yes / No Currently Using Nocturnal Oxygen ____LPM
Yes / No Needs Crib
Yes / No Neurologically Impaired
Yes / No Wheelchair Dependent

Weight =______ Height = ______

* Specific Information & Questions Related to PAP Titration

Please discuss CPAP/BiPAP with the patient prior to the study if you are ordering a TITRATION study.

- By signing this form, I authorize the Sleep Center to send a script for the recommended treatment (CPAP/BiPAP/O2) to the Durable Medical Equipment (DME) company specified by the patient. ***Check if a prescription is NOT needed ____***

- By signing this form, I request that the Sleep Center schedule this patient for an Ambulatory Sleep Consult approximately 6-8 weeks after this PAP Titration. ***Check if a Sleep Consult is NOT needed ____***

Specific Objectives of Consult/Sleep Study:

____R/O Sleep Apnea
____Parasomnia
____Insomnia or Circadian Disorder
____R/O Hypoventilation/Hypoxemia
____Seizure
____Behavioral Sleep Disorder
____CPAP/BiPAP Titration
____RLS/PLMS
____Unspecified Sleep Disorder

For Prompt Scheduling, Please Include:

- **Relevant Office Notes, Problem List, Medication List**
- **Insurance Information**
- **Any Previously Performed Sleep Testing (outside our center)**

Date: _____ Provider Signature: __________________

Ordering Provider: ___________________(Printed) Department: ______________________

*****FOR SLEEP CENTER USE*****

Hospital ____ One on One____ Crib ____ Oxygen____ TcCO2____

Dunning / Feb 2016