Sleep Study Referral Form

Sleep Disorders Center

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 as a member of the Sleep Team will contact the family for scheduling:

- most recent H&P and/or clinic note on the patient you are referring
- insurance & demographic information

fax to: 402-955-3693

Today's Date: ____________________
Patient Name: ____________________
Date of birth: ____________________
Parent/Guardian Name: ____________________

Referring Provider: ____________________
Provider Specialty: ____________________
Phone: ____________________
Fax: ____________________
Primary Care Physician: ____________________

Patient's Current Diagnoses:

- ☐ Difficulty breathing while asleep
- ☐ Witnessed Apnea
- ☐ Tonsillar or Adenoid Hypertrophy
- ☐ Tracheostomy
- ☐ Craniofacial Abnormalities
- ☐ Down Syndrome
- ☐ Neuromuscular Disease
- ☐ Autism Spectrum Disorder
- ☐ Obstructive Sleep Apnea
- ☐ Central Sleep Apnea
- ☐ Hypoventilation
- ☐ Hypoxemia
- ☐ Periodic Limb Movements
- ☐ Restless Leg Syndrome
- ☐ Prior ENT Surgeries (type & date) : ____________________
- ☐ Insomnia
- ☐ Hypersomnia
- ☐ Parasomnia
- ☐ Obesity
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Other: ____________________

Purpose of the study:

- ☐ Evaluate for Obstructive Sleep Apnea
- ☐ To determine if decanulation candidate
- ☐ Need for tracheostomy
- ☐ Determine if surgical candidate
- ☐ Surgery (type & date) : ____________________
- ☐ Evaluate for Central Sleep Apnea
- ☐ Evaluate for O2 therapy
- ☐ Determine if needs CPAP or BiPAP
- ☐ Evaluate for periodic limb movements
- ☐ Other : ____________________

Routine Polysomnogram Orders (*check all that apply*)

- ☐ Routine PSG on room air
- ☐ Do not schedule until after ________________(date)
- ☐ Interpreter needed (language ____________________)
- ☐ URGENT (please call sleep center at 402-955-7378)
- ☐ Additional Orders: ____________________
- ☐ Start study with supplemental O2 at ______ Lpm
- ☐ CPAP or BiPAP titration study
  - current settings: ____________________
  - start study on: ____________________

Provider Signature/Date: ____________________

Above referral will be reviewed and patient may be asked to be seen in clinic prior to scheduling the sleep study.

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