Pediatric Sleep and Breathing Disorders Center

Weill Cornell Medicine
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Weill Cornell Medical Center

PT. NAME _____ **DOB:** _____ **SEX: M/F**
HOME PHONE: _____ **MOBILE PHONE** _____
WORK PHONE: _____ **EMAIL:** _____
ADDRESS: _____ **CITY:** _____ **ZIP:** _____
INTERPRETER NEEDED: Y/N IF YES, PREFERRED LANGUAGE: _____
DIAGNOSIS: _____

EMERGENCY CONTACT:
PARENT/GAURDIAN NAME: _____ **DOB:** _____ **PHONE #**_____
ADDITIONAL CONTACT: _____ **PHONE #**_____

HEALTH INSURANCE INFORMATION:
INSURANCE CO._____ **I.D. #**_____**GROUP #**_____
INS. PHONE:_____ **INSURED NAME:** _____
PLEASE PROVIDE A COPY OF INSURANCE CARD, BACK AND FRONT, TOGETHER WITH PROGRESS NOTES FOR AUTHORIZATION PURPOSES

REFERRING PHISICIAN:
PHYSICIAN NAME: _____ **SPECIALTY:** _____
PHONE # _____ **FAX #**_____
ADDRESS: _____ **CITY:** _____ **ZIP:** _____
PCP NAME: _____ **PHONE #** _____

INSTRUCTION FOR STUDY:
☐ **Obstructive sleep apnea** ☐ **Central sleep apnea** ☐ **Hypoventilation** ☐ **Insomnia** ☐ **Hypoxemia**
☐ **CPAP/BiPAP titration** ☐ **GERD/PH Probe** ☐ **Obesity** ☐ **Narcolepsy**
☐ **Split night study** ☐ **Restless Leg Syndrome** ☐ **MSLT**
SPECIAL INSTRUCTIONS: _____

Would you like the patient to be seen by a Pediatric Sleep Specialist at The Pediatric Sleep Disorders Center prior to the sleep study? Yes☐No☐

SLEEP HISTORY:
Does, or has, the patient:
Snore excessively more than 3 nights a week? YES☐ NO☐
Been observed to stop breathing or have pauses in breathing during sleep? YES☐NO☐
Awaken with gasping, choking, dry mouth or throat? YES ☐ NO☐
Tend to be a "mouth breather"? YES☐ NO☐
Occasionally wets the bed (for children 3 and older)? YES☐ NO☐
Feel sleepy or fatigued during the day? YES☐ NO☐
Have poor school performance? YES ☐ NO ☐
Have hyperactivity or is inattentive? YES☐ NO☐
Suffers from morning headaches? YES ☐ NO ☐
Experience a restless sensation in arms or legs during sleep or in the evening? YES ☐ NO☐
Been told that they make kicking movements during sleep? YES ☐ NO☐
Have difficulty falling asleep at the beginning of the night? YES ☐ NO☐
Have difficulty staying awake during the day? YES ☐ NO☐
Have sudden loss of strength in arms or legs while awake? (Induced by strong emotion) YES ☐ NO☐
Had a previous sleep study? YES ☐ NO ☐
If so, when and where?_____
How long does it typically take the patient to fall asleep?_____
Usual Bedtime:_____PM Usual wake-up time: _____AM

MEDICAL HISTORY: **(PLEASE FAX HISTORY & PHYSICAL)**
☐ Asthma ☐ Enlarge tonsils ☐ Deviated septum ☐ Gastroesophogeal Reflux ☐ Allergies
☐ Enlarged adenoids ☐ Nasal obstruction ☐ Craniofacial Malformation ☐ Obesity ☐ Previous T&A?
☐ Enlarged Tongue ☐ Seizures ☐ Cardiac problems ☐ Nasal polyps ☐ Diabetes
☐ Other Medical History/Allergies: _____

Height: _____, Weight: _____, **MEDICATIONS**:_____

I AUTHORIZE LAB TO PERFORM SLEEP STUDIES ON ABOVE PATIENT ACCORDING TO THEIR PROTOCOLS, INCLUDING URGENT INITIATION OF O2 & CPAP.

PHYSICIAN (Print)**:** _____**SIGNATURE:** _____ **DATE:**_____