

Pediatric Sleep and Breathing Disorders Center



**Weill Cornell
Medicine**

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**NewYork-Presbyterian
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Weill Cornell Medical Center

PT. NAME _____ DOB: _____ SEX: M/F HOME PHONE: _____ MOBILE PHONE: _____ WORK PHONE: _____ EMAIL: _____ ADDRESS: _____ CITY: _____ ZIP: _____ DIAGNOSIS: _____	
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 # _____	
EMERGENCY CONTACT: PARENT/GAURDIAN NAME: _____ DOB: _____ PHONE # _____ ADDITIONAL CONTACT: _____ PHONE _____	
INSTRUCTION FOR STUDY: <input type="checkbox"/> Obstructive sleep apnea <input type="checkbox"/> Central sleep apnea <input type="checkbox"/> Hypoventilation <input type="checkbox"/> Insomnia <input type="checkbox"/> Hypoxemia <input type="checkbox"/> CPAP/BiPAP titration <input type="checkbox"/> GERD/PH Probe <input type="checkbox"/> Obesity <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Split night study <input type="checkbox"/> Restless Leg Syndrome <input type="checkbox"/> 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 Gastroesophageal 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:** _____