SLEEP STUDY REFERRAL

Pediatric Sleep Medicine Services

GOLISANO CHILDREN'S HOSPITAL

To request a sleep study only, please fill out this form and fax to (585) 785-9901. Direct referrals for sleep studies will only be accepted from otolaryngologists, pediatric pulmonologists, pediatric neurologists and the hypertension clinic. *This form is only for sleep studies, not a consultation.*

Patient Name: _____

MRN #: _____ DOB : _____ SEX : _____

Address: _____

City:_____ State : _____ ZIP: _____

Mother's Name:_____ Father's Name:_____

Home Phone:_____

Work Phone (Mother):_____ Work Phone (Father):_____

Insurance: _____ Referral Number (if needed):_____

PCP First and Last Name: _____

Please select type of study:

❑ NPSG (overnight sleep study) ❑ NPSG and MSLT (overnight sleep study and multiple latency test)

Diagnosis for study: Reason for Study:

❑ Obstructive Sleep Apnea ❑ Excessive daytime sleepiness ❑ Central Sleep Apnea

❑ Observed snorts/apneas ❑ Narcolepsy ❑ Nightly snoring ❑Other: _____

Does this patient have special needs (please specify)?: _____

Is the patient on oxygen at night? ❑ NO ❑ YES

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Referring Physician: _____ Phone: _____ Fax: _____
(Please print clearly)

Referring Physician Signature: _____ Date: _____

A member of our team will contact your patient in a timely manner. Thank you.

Strong Sleep Disorders Center
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MEDICINE of THE HIGHEST ORDER