Rhode Island Hospital
Lifespan. Delivering health with care.®

Pediatric Polysomnography (Sleep Study) Request Form
Lifespan Sleep Disorders Center
Scheduling: 401-431-5420 • Fax: 401-431-5429

MR # _____

Patient Information

PATIENT NAME _____ SEX M ☐ F ☐

DOB _____ /_____ / _____ SOCIAL SECURITY NUMBER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

ORDERING PHYSICIAN _____ DATE _____

PRINT NAME _____ SIGNATURE _____

PRIMARY PHYSICIAN _____ AUTHORIZATION # _____

VALID AUTHORIZATION DATES _____

Insurance Information

PRIMARY INSURANCE _____

POLICY # _____ GROUP # _____

INSURANCE TELEPHONE _____

POLICY HOLDER NAME _____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE _____

POLICY # _____ GROUP # _____

INSURANCE TELEPHONE _____

POLICY HOLDER NAME _____

RELATIONSHIP TO PATIENT _____

Diagnosis	Primary	2	3	Patient's Normal Bedtime/Normal Wake-Up Time:
Supplemental O2 Needed	Yes	No	Amount	Late sleeper?
Necessity of Study	Elective	Urgent	Emergent	Comment/special needs:

Tests/Procedures (Check all that apply and enter ICD-10 diagnosis code for each test ordered)

√	Test	ICD-10	√	Test	ICD-10
	Baseline Study			CPAP Titration	
	½ Baseline and ½ CPAP			Bilevel Titration Spontaneous	
	½ Baseline and ½ Bilevel			Efficacy PAP with set pressure at _____ cm H2O	
	Dental Appliance Titration			Multiple Sleep Latency Test or Maintenance of Wakefulness Test	
	Other: (Specify):			Special Instructions:	

Do you want your patient seen in follow-up at the Hasbro Children's Hospital Pediatric Sleep Medicine program? Y ☐ N ☐

HAS PATIENT BEEN GIVEN INFORMATION PACKET? Y ☐ N ☐

DATE OF STUDY _____ TIME _____ HASBRO _____ EP _____ EG _____

FOLLOW-UP VISIT _____ DATE _____ TIME _____ LOCATION _____

PLEASE BE ADVISED THAT SLEEP STUDY RESULTS TAKE 2 WEEKS TO BE GENERATED

Lifespan Sleep Disorders Center Pediatric Symptoms & History

PATIENT NAME _____ DOB _____ /_____ / _____

CELL PHONE _____ HOME PHONE _____ WORK PHONE _____

PLEASE TELL US WHY THE PATIENT NEEDS A SLEEP STUDY _____

_____

Sleep History (Check all that apply)					
	Loud snoring		Daytime sleepiness		Sleep walking
	Choking/gasping arousals		Difficulty falling asleep		Sleep terrors
	Observed apneas during sleep		Night waking		Circadian rhythm problems
	Restless sleep		Restless leg symptoms		Other
	Sweating during sleep				

Major Medical Problems (Check all that apply)					
	Allergies		Failure to thrive		Hypotonia
	Sinus Problems		Frequent otitis media		Behavioral problems
	Hypertension		Adenotonsillar hypertrophy		Academic problems
	Gastroesophageal reflux		Adenodectomy/tonsillectomy		ADHD
	Obesity		Craniofacial anomalies		Other

Medications: (fill in or attach list) _____

- NO MEDICIATION (Please circle if patient is not currently on any medications)
- Does Patient have any special needs? If so, please fill out “How We May Help You” form.
- Is there need for an interpreter? YES ☐ NO ☐

Please send a copy of the patients last office visit note along with this form

Site Request: ☐ Hasbro ☐ East Providence ☐ East Greenwich

Please Note: Hasbro tests of ages up to 18. E. Providence and E. Greenwich tests patients 8 and older.

Physician Name _____ Physician Signature _____

Date _____ /_____ / _____ Phone _____ Fax _____

Please specify:

F/U with: ☐ Referring MD ☐ PCP or Other

Note: An appointment with the Pediatric Sleep Clinic specialist requires a separate referral form.

How May We Help You?

Please inform us of any needs or equipment that you may require so we can better accommodate you during your study. Please call 401-431-5420. Thank you.

Please inform us if you have any of the following:

- Oxygen at night? _____ Liters of oxygen _____
- Trach tube (Please bring **all** connections, humidification, and suction equipment etc.)
- Ventilator (Please bring **all** connections, humidification, and suction equipment etc.)

Do you need:

- Translator _____ Spanish _____ Other _____

Physical assistance with:

- Getting in and out of bed
- Help in the bathroom
- Walking/ mobilization
- Room close to bathroom
- Other needs not listed _____

Equipment:

- Cpap/bipap mask (Please bring mask and head gear only)
- Side rails
- Urinal or bedpan
- Wheelchair
- Hoyer lift
- Suction equipment (Please bring)
- Ventilator (Please bring all connections, humidification, and suction equipment etc.)
- Other equipment not listed _____

Accommodations:

- Pull out bed for caregiver
- Bed rails
- Attendant or nursing assistant
- Other items not listed _____