PACIFIC SLEEP PROGRAM

Pediatric Referral Form: Ages 11-17

Portland Office:
11790 SW Barnes Rd, STE 330 Portland, OR 97225
Phone: (503) 228-4414
Fax: (503) 228-7293

PLEASE INCLUDE CHART NOTES, MEDICATION LIST AND FRONT/BACK OF RECENT INSURANCE CARDS

Patient Name:		**Date of Birth:**	
Parent/Guardian Name:		**Parent/Guardian DOB:**	
Home/Work Phone:		Cell Phone:	
Primary Insurance:		Primary Insurance ID:	
Secondary Insurance:		Second Insurance ID:	

MEDICAL HISTORY (a history and physical exam is required)

Suspected Diagnosis:	**Signs/Symptoms:**	**Past Medical History:**	**Special Needs:**
○ Sleep apnea ○ Restless leg syndrome ○ Insomnia ○ Narcolepsy	○ Snoring ○ Witnessed apnea ○ Obesity ○ Daytime sleepiness ○ Hyperactivity ○ Behavioral issues	○ CAD ○ HTN ○ Stroke ○ COPD ○ Tonsillar enlargement ○ Tonsillectomy +/- Adenoidectomy ○ ADD/ADHD	○ Nocturnal O2: L/min ○ Wheelchair ○ Medical Interpreter

Patient is being referred for (check only ONE):

○ **Consultation and Management**. Visit with a sleep specialist to evaluate and treat patient.

Or, a Direct Sleep Study (Listed below) – In which the Ordering provider is responsible for discussing test results with patient and initiating treatment, if indicated.

○ **Diagnostic Polysomnogram**: Full night sleep study

ORDERING CLINICIAN INFORMATION

Name:_____ Signature:_____

Address:_____ Phone:_____ Fax:_____