



SLEEP LAB PHYSICIAN ORDER

Apply Patient Label

Phoenix Children's Pediatric Sleep Lab

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To order a sleep study: **PHONE: (602) 933-1642 • FAX: (602) 933-2447**

Patient name: _____ DOB: _____
Address: _____ City: _____ Zip: _____
Home phone: _____ Mobile phone: _____ Daytime phone: _____
Ordering physician: _____
Contact person: _____ Phone: _____ Fax: _____
Insurance (send copy of card): _____ ID #: _____
Authorization #: _____ Group #: _____

Referrals for Insomnia Testing require Sleep Program Physician Consultation. Please attach a copy of the patients most recent clinical encounter documenting details of the sleep history, physical exam, and reason for referral.

Would you like a follow up appointment with one of the sleep medicine physicians?
 Pulmonologist Neurologist No follow up

Please check all symptoms that apply to this patient.

<input type="checkbox"/> Probable obstructive sleep apnea with snoring or observed apneas					
<input type="checkbox"/> Cataplexy	<input type="checkbox"/> Leg movements during sleep	<input type="checkbox"/> Prior diagnosis of sleep apnea			
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Frequent arousals from sleep				
<input type="checkbox"/> Unusual movements/behavior during sleep	<input type="checkbox"/> Daytime sleepiness (hypersomnolence)	<input type="checkbox"/> Parasomnias			
<input type="checkbox"/> Gastroesophageal reflux	<input type="checkbox"/> Obesity BMI:	<input type="checkbox"/> Adenotonsillar hypertrophy	<input type="checkbox"/> Autism	<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Uses wheelchair
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Allergies	<input type="checkbox"/> Craniofacial anomalies	<input type="checkbox"/> Sickle cell disease		<input type="checkbox"/> Seizures
<input type="checkbox"/> S/P T&A Date:	<input type="checkbox"/> Asthma	<input type="checkbox"/> Neuromuscular disease/CP	<input type="checkbox"/> Prematurity/BPD	<input type="checkbox"/> Uses PAP/Oxygen/vent at home	
<input type="checkbox"/> Other:					
Previous sleep studies? <input type="checkbox"/> Yes, Phoenix Children's lab <input type="checkbox"/> Other lab (If so, please attach previous sleep study results)					

Test(s) to be performed:

Consultation in clinic Polysomnography: 95810 (attended > 6 yrs.) 95782 (attended PSG < 6 yrs.)
 95811 (attended CPAP/Bilevel/vent > 6 yrs.) 95738 (attended CPAP/Bilevel/vent < 6 yrs.)
 95800 (unattended 4 channel)

Preferred PSG Reader: Pulmonologist Neurologist

Ordering Provider's Signature: _____

Printed Name: _____ Date: _____ Time: _____

