Riley Hospital for Children
Indiana University Health

SLEEP MEDICINE SERVICE REQUEST

Patient Name:

Date of Birth:

Insurance:

Patient Telephone:

Patient Address:

Email:

OUTPATIENT SLEEP MEDICINE CONSULT (MUST CALL)
Medical sleep problem — 317-948-7208
Behavioral sleep consult — 317-948-7208

705, Riley Hospital Dr, ROC 4270
Indianapolis, IN 46202
Telephone: 317-944-9650
FAX: 317-944-0508

❶

	OVERNIGHT POLYSOMNOGRAM
	DAYTIME NAP (4-6 HR) POLYSOMNOGRAM (Patient < 3mo only)
	OVERNIGHT POLYSOMNOGRAM WITH VIDEO EEG
	CPAP OR BIPAP TITRATION
	DECANNULATION STUDY *(DAYTIME NAP FOLLOWED BY OVERNIGHT PSG)*
	VENTILATOR WEANING STUDY *(must give parameters-see below)*
	VENTILATOR TITRATION STUDY *(must give parameters-see below)*
	MULTIPLE SLEEP LATENCY TEST (MSLT) (must follow overnight PSG)
	ACTIGRAPHY *(requires Sleep Medicine/Behavior Consult)*
	CPAP CLINIC REFERRAL (RESP THERAPY AND/OR PSYCHOLOGIST)

TITRATION PARAMETERS: SpO2> _____ ETCO2< _____ Settings _____
or Titrate to optimal CPAP / BIPAP / Ventilator / O2 settings

❷

INDICATIONS FOR PSG
(insurance approved indications)
If these do not apply to your patient, please call sleep physician

Assess for sleep apnea; Snoring	Strider
Periodic leg movements	Titrate CPAP, 02, BIPAP, Ventilator
Parasomnias vs Seizures	Excessive day-time sleepiness
Neuromuscular Disease	Narcolepsy
Hypoventilation	PostT&A

❸ ***DIAGNOSIS** _____

OFFICE USE ONLY:
Date rec'd:_____
Date scheduled:
By:_____

***ATTACH RECENT CLINIC NOTE OR CIRCLE PERTINENT FINDINGS**

HISTORY	Snoring	Apnea	Strider	Excessive sleepiness	Parasomnias	Asthma	Seizures	Developmental delay	Neuromuscular disease
PHYSICAL	Mallampati score:	Tonsillar hypertrophy	Nasal obstruction	Mouth breathing	Wheezing Crackles	Scoliosis	Muscle weakness	Spasticity	

❹ **THE ORDERING PROVIDER IS RESPONSIBLE FOR COMMUNICATION OF THE STUDY RESULTS TO THE PATIENT AND PATIENT MANAGEMENT DECISIONS** (SEVERELY ABNORMAL STUDIES WILL BE STAMPED URGENT)

***FAX NUMBER FOR RESULTS TO BE SENT:**_____

❺ ***CONTACT NUMBER FOR SIGNIFICANTLY ABNORMAL STUDIES (REQUIRES INTERVENTION URGENTLY)**
(SpO2 <90% FOR 20 MIN; ETCO2 >65 TORR OR AHi > 30) _____

OR

***AUTHORIZATION FOR MANAGEMENT OF PATIENTS WITH SIGNIFICANTLY ABNORMAL STUDIES BY THE PEDIATRIC SLEEP SPECIALIST AND/OR RILEY ENT:** _____ (SIGNATURE)

***(If no phone number is included nor authorization signed and we are not able to reach you or your covering provider, patient will be sent to the Emergency Department)**

❻ ORDERING PROVIDER SIGNATURE:_____ DATE:_____

ORDERING PROVIDER NAME:_____ PHONE #_____

PRIMARY CARE PROVIDER:_____ PHONE#_____

Office use only: Date reviewed _____ by _____ Approved Y N _____

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