CHOC Children's Specialists

Sleep Study Referral Request

Department Phone: 714.509.8651 Fax: 714.509.8652

Thank you for referring your patient to the CHOC Sleep Center.

Patient Information

Does the patient live with someone other than the legal guardian? ☐ No ☐ Yes, relationship_____

Patient Name: _____ Date of Birth: _____ / _____ / _____

Parent/Guardian: _____ Parent Phone: _____

Insurance: _____ Parent Cell: _____

1. Is this an emergent request for a Sleep Study? ☐ No ☐ Yes **If yes, requires a phone call from an MD /PA /NP with clinical information to 714.509.8709**

2. What is your specific sleep related concern?

_____

_____

_____

Symptoms or concerns – please check all that apply

☐ **ADHD/Difficult behaviors**	☐ **Obesity**
☐ **BiPAP/CPAP**	☐ **Periodic/abnormal breathing pattern**
☐ **Daytime sleepiness**	☐ **Restless sleep/frequent movements**
☐ **Enlarges tonsils/adenoids**	☐ **Sleep talking/walking**
☐ **Nightmares/Night terrors**	☐ **Snoring**
☐ **Nocturnal seizures**	☐ **Stops breathing/apnea**

To expedite appointment scheduling, please provide the following by FAX 714-509-8652:

- ☐ **This completed form**
- ☐ **Medical records related to the chief complaint**
- ☐ **Previous sleep study report, if applicable.**
- ☐ **Patient demographics**
- ☐ **Provider signed prescription/ order**
- ☐ **Authorizations required:**
  - Polysomnography >6 years old : 95810
  - Polysomnography w/CPAP/BiPAP >6 years old : 95811
  - Polysomnography <6 years old : 95782
  - Polysomnography w/CPAP/BiPAP <6 years old : 95783
  - Multiple Sleep Latency Test : 95805
  - Daytime Nap Study (patients <1 year of age) : 95808-52

Referring Provider Name: _____ Phone: _____ Fax:_____

Provider Address:_____ City: _____ Zip: _____