SLEEPWELL KIDS
A division of Asthma & Allergy Specialists, P.A.

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PEDIATRIC SLEEP CONSULT REFERRAL FORM

Please complete entire page and fax referral form along with copy of insurance card, demographics, and office notes to (866) 731-3822

Date: _____

Patient Information

Patient Name:_____ **Date of Birth**:_____

Parent/Guardian Name:_____ ☐ **Spanish Speaking**

Patient Address: _____
Street City State Zip

Primary Contact #: _____ **Secondary Contact #**:_____

Email Address:_____

Insurance Information

Primary Insurance: _____ **Policy #**:_____
Secondary Insurance:_____ **Policy #**: _____

Referring Provider Information

Referring Provider:_____ **Phone #**:_____
Fax #:_____ **Contact Name**:_____

Primary Care Provider (if different):_____ **Phone #**_____

Description of Symptoms:

- ☐ **Witnessed Apnea**
- ☐ **Gasping**
- ☐ **Restless/Disturbed Sleep**
- ☐ **Mouth Breathing**
- ☐ **Excessive Breathing**
- ☐ **Excessive Daytime Somnolence**
- ☐ **Snoring**
- ☐ **Difficulty Arousing**
- ☐ **Headaches (Primarily in the AM)**
- ☐ **Nocturnal Hypoxia/Lowered O2 Saturations**
- ☐ **GERD**
- ☐ **ADD/ADHD**
- ☐ **Suspect Nocturnal Seizures**
- ☐ **Cyanosis**
- ☐ **Other:**_____

PATIENTS WILL BE SEEN IN OFFICE FOR CONSULT BEFORE A SLEEP STUDY WILL BE SCHEDULED

APPOINTMENT SCHEDULED

Date: _____ **Time:** _____ **Dr.** _____ **Location:**_____