Bon Secours Sleep Disorder Institute
at St Anthony Community Hospital
74 North Main Street, Florida NY 10921
Phone (866) 857-6080 Fax (888) 367-6555

ST. ANTHONY COMMUNITY HOSPITAL
MOUNT ALVERNO - SCHERVIER PAVILION - DAY AT A TIME
Bon Secours Charity Health System

Pediatric SLEEP STUDY REFERRAL FORM

PATIENT INFORMATION:

NAME:_____ **HEIGHT:**_____ **WEIGHT:** _____ **DOB:** _____ **SEX:**____
SOCIAL SEC. #_____ **ADDRESS:** _____
HOME PHONE:_____ **CITY/ST/ZIP:** _____
WORK PHONE:_____ **CELL PHONE/OTHER#**_____

INSURANCE INFORMATION:

INSURED NAME: _____ **INSURED SS#:**_____ **INSURED DOB:** _____
INS. CO._____ **I.D. #**_____**GROUP #**_____

PHYSICIAN INFORMATION:

NAME:_____ **PHONE:**_____
ADDRESS:_____ **FAX:**_____
CITY/ST/ZIP:_____ **SPECIALTY:**_____
SEND REPORT TO ABOVE: ☐**YES** ☐**NO** **IF NO, SEND TO ADDRESS/FAX:**_____

STUDY REQUESTED: History/Physical notes of office visit must accompany this referral

☐ Diagnostic Sleep Study – Polysomnogram (PSG)	CPT-95810 or 95782
☐ Titration with CPAP for OSA (no $ETCO_2$)	CPT-95811 or 95783
☐ Titration with BPAP for OSA (no $ETCO_2$)	CPT-95811 or 95783
☐ Titration with BPAP for hypoventilation (**with $ETCO_2$**)	CPT-95811 or 95783
☐ Split night study (PSG, with switch to PAP if AHI ≥ 20)	CPT-95811 ± 95783
☐ PSG w/Multiple Sleep Latency Test (MSLT)	CPT-95810 & 95805

SPECIAL INSTRUCTIONS / NEEDS:_____
Patient has a trach? ☐Yes ☐No If yes, do you wish trach ☐OPEN ☐CLOSED
Patient on Supp. Oxygen? ☐Yes ☐No If yes, do you wish O2 during the test? ☐Yes ___L/min ☐No

I would like my patient seen in consultation with the Pediatric Sleep Specialist ☐Before ☐After testing.

REFERRING DIAGNOSIS: (Must check at least ONE)

☐ Obstructive Sleep Apnea (327.23) ☐ Restless Leg Syndrome/Periodic Limb movements (327.51)
☐ Central Sleep Apnea (327.27) ☐ Daytime Sleepiness (327.10) ☐ Parasomnias (307.40)
☐ Hypoventilation (327.26) ☐ Narcolepsy (347) ☐ Other_____

INDICATIONS: (Must check at least TWO)

☐ Snoring ☐ Morning headaches ☐ Waking feeling tired
☐ Daytime sleepiness/napping ☐ Leg kicking while asleep ☐ Restless sensation in arms/legs
☐ Witnessed apnea ☐ Restless sleep ☐ Awaken with gasping or choking sensation
☐ Difficulty falling/staying asleep ☐ Impaired cognition ☐ Irritability
☐ Sleep paralysis ☐ Sudden loss of muscle strength brought on by strong emotion
☐ Other: _____

MEDICAL HISTORY: (Must check all that apply or NONE)

☐ Obesity ☐ Asthma ☐ Mood Disorder ☐ GERD
☐ Large tonsils ☐ Allergies ☐ Craniofacial malformation ☐ Neuromuscular weakness
☐ Large adenoids ☐ Prior T&A ☐ Nasal Obstruction ☐ Seizures
☐ Cardiac Problems ☐ Other _____ ☐ **NONE**
☐Currently on CPAP/Bi-Level _____cm H_2O, rate_____ ☐ **ALLERGIES (Please Note):** _____
☐ Previous Sleep Study (location & date): _____

I AUTHORIZE SSA TO PERFORM SLEEP STUDIES ON ABOVE PATIENT ACCORDING TO THEIR PROTOCOLS, INCLUDING URGENT INITIATION OF O2 & CPAP.

PHYSICIAN SIGNATURE:_____**DATE:**_____