NeuroCare CENTER FOR SLEEP

Newton

Pediatric Sleep Testing oneForm Request

please fax completed form with most recent office notes to: 617-796-9099

For questions, please call: 617-796-7766

DEMOGRAPHIC INFORMATION

Patient Name: _____ DOB: _____ English Proficient? ☐ Yes ☐ No

Patient Phone Numbers: Mobile #: _____ Home#: _____ Alternate #: _____

Insurance Provider: _____ Insurance ID #: _____

☐ Patient has had previous sleep testing *(Study report must be submitted if completed at another facility)*

☐ Previous sleep study completed but is unavailable

SLEEP STUDY REQUESTED

☐ **Polysomnography:** All night diagnostic sleep study (PSG) to evaluate for all sleep disorders.

☐ **PAP Titration***: Titrate positive airway pressure to optimal pressure level.
Diagnosis confirmed by PSG. **Date of PSG:**_____

SPECIAL NEEDS/ASSISTANCE *(please specify)*

☐ Developmental disability:

☐ Mobility/functional disability:

☐ Medication/environmental allergies:

INDICATION *(suspected sleep disorder)*

☐ Sleep Apnea/Upper Airway Resistance Syndrome

☐ Periodic Limb Movement Disorder

☐ Restless Leg Syndrome

SYMPTOMS *(select at least two)*

☐ Excessive daytime sleepiness

☐ Disruptive snoring

☐ Frequent arousals/disturbed or restless sleep

☐ Witnessed apneas

☐ Labored breathing during sleep

☐ Enlarged tonsils/adenoids

☐ Leg movements, jerks, cramps

☐ Insomnia

☐ Sleep Walking

☐ Bedwetting

☐ Irregular breathing/pauses in breathing during sleep

☐ Aggressive behavior

☐ Poor school performance

☐ Failure to thrive/growth impairment

☐ Polycythemia

☐ Other:

DOCUMENTED COMORBIDITIES & MEDICAL HISTORY

☐ ADD/ADHD

☐ Seizures

☐ Neuromuscular disorder:

☐ Other:

I acknowledge that the clinical information submitted to support this request is accurate and specific to this patient, and all information has been provided. I authorize submission of this information for precertification on my behalf.

Ordering Provider Signature: _____ Date: _____

Print Name: _____ NPI: _____