

SLEEP STUDY REFERRAL

Pediatric Sleep Medicine Services

GOLISANO
CHILDREN'S HOSPITAL

To request a sleep study only, please fill out this form and fax to (585) 785-9901. Direct referrals for sleep studies will only be accepted from otolaryngologists, pediatric pulmonologists, pediatric neurologists and the hypertension clinic. This form is only for sleep studies, not a consultation.

Patient Name: _____

MRN #: _____ DOB : _____ SEX : _____

Address: _____

City: _____ State : _____ ZIP: _____

Mother's Name: _____ Father's Name: _____

Home Phone: _____

Work Phone (Mother): _____ Work Phone (Father): _____

Insurance: _____ Referral Number (if needed): _____

PCP First and Last Name: _____

Please select type of study:

NPSG (overnight sleep study) NPSG and MSLT (overnight sleep study and multiple latency test)

Diagnosis for study: Reason for Study:

Obstructive Sleep Apnea Excessive daytime sleepiness Central Sleep Apnea

Observed snorts/apneas Narcolepsy Nightly snoring Other: _____

Does this patient have special needs (please specify)?: _____

Is the patient on oxygen at night? NO YES

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Referring Physician: _____ Phone: _____ Fax: _____
(Please print clearly)

Referring Physician Signature: _____ Date: _____

A member of our team will contact your patient in a timely manner. Thank you.

Strong Sleep Disorders Center
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