



Pediatric Referral Form: Ages 3-17

Portland Office:

11790 SW Barnes Rd, STE 330 Portland, OR 97225
 Phone: (503) 228-4414
 Fax: (503) 228-7293

Astoria Office:

2120 Exchange St, STE 302 Astoria, OR 97103
 Phone: (503) 325-3126
 Fax: (503) 325-4933

PLEASE INCLUDE CHART NOTES, MEDICATION LIST AND FRONT/BACK OF RECENT INSURANCE CARDS

Patient Name:		Date of Birth:	
Parent/Guardian Name:		Parent/Guardian DOB:	
Home/Work Phone:		Cell Phone:	
Primary Insurance:		Primary Insurance ID:	
Secondary Insurance:		Second Insurance ID:	

MEDICAL HISTORY (a history and physical exam is required)

<u>Suspected Diagnosis:</u>	<u>Signs/Symptoms:</u>	<u>Past Medical History:</u>	<u>Special Needs:</u>
<ul style="list-style-type: none"> <input type="radio"/> Sleep apnea <input type="radio"/> Restless leg syndrome <input type="radio"/> Insomnia <input type="radio"/> Narcolepsy 	<ul style="list-style-type: none"> <input type="radio"/> Snoring <input type="radio"/> Witnessed apnea <input type="radio"/> Obesity <input type="radio"/> Daytime sleepiness <input type="radio"/> Hyperactivity <input type="radio"/> Behavioral issues 	<ul style="list-style-type: none"> <input type="radio"/> CAD <input type="radio"/> HTN <input type="radio"/> Stroke <input type="radio"/> COPD <input type="radio"/> Tonsillar enlargement <input type="radio"/> Tonsillectomy +/- Adenoidectomy <input type="radio"/> ADD/ADHD 	<ul style="list-style-type: none"> <input type="radio"/> Nocturnal O2: L/min <input type="radio"/> Wheelchair <input type="radio"/> Medical Interpreter

Patient is being referred for (check only ONE):

- Consultation and Management.** Visit with a sleep specialist to evaluate and treat patient.

Or, a Direct Sleep Study (Listed below)– In which the Ordering provider is responsible for discussing test results with patient and initiating treatment, if indicated.

- Diagnostic Polysomnogram:** Full night sleep study

ORDERING CLINICIAN INFORMATION

Name: _____

Signature: _____

Address: _____

Phone: _____ Fax: _____