



# Wise Health System

## Sleep Wellness Center



**Please attach a copy of the patients: Insurance card Demographics Current H&P**

### Pediatric Sleep Order Form

2000 S FM 51. Decatur, Texas 76234  
Phone: 940-626-8818  
Fax: 940-626-8819

\_\_\_\_\_  
**Patient Name** (Required)                      **Sex**                      **Date of Birth** (Required)                      **Social Security #**

\_\_\_\_\_  
**Address**                      **City**                      **State**                      **ZIP Code**

\_\_\_\_\_  
**Parent or Guardian's Name**                      **Cell Phone** (At least one is required)                      **Home Phone**

### **Assessment/Indications**

#### Clinical Indication for Referral:

- |   |  |
|---|--|
| <input type="checkbox"/> Obstructive Sleep Apnea (G47.33)         | <input type="checkbox"/> Down Syndrome (Q90.9)         |
| <input type="checkbox"/> ADHD (F90.9)                             | <input type="checkbox"/> Craniofacial Disorder (Q75.9) |
| <input type="checkbox"/> Asthma (J45.909)                         | <input type="checkbox"/> ALTE (R68.13)                 |
| <input type="checkbox"/> Periodic Limb Movement Disorder (G47.61) | <input type="checkbox"/> Narcolepsy (G47.411/G47.4119) |
| <input type="checkbox"/> Organic Sleep Related Movement Disorders | <input type="checkbox"/> Cardiac Arrhythmias           |
|   | <input type="checkbox"/> Other: _____                  |

#### Associated Symptoms:

- |   |   |
|---|---|
| <input type="checkbox"/> Loud Snoring                 | <input type="checkbox"/> Enuresis (N39.44)                    |
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Leg Movements                        |
| <input type="checkbox"/> Night Terrors                | <input type="checkbox"/> Nasal/sinus allergies                |
| <input type="checkbox"/> Sleep Walking                | <input type="checkbox"/> Seizures, Sleep Twitching or Jerking |
| <input type="checkbox"/> Obesity (E66.8)              | <input type="checkbox"/> Other: _____                         |

### **HEENT Examination:**

#### Tonsils

- Present  
 Enlarged  
 Removed  
 Date of Surgery \_\_\_\_\_

#### Adenoids

- Present  
 Enlarged  
 Removed  
 Date of Surgery \_\_\_\_\_

### **Orders**

#### Sleep Services Ordered:

- |   |  |
|---|--|
| <input type="checkbox"/> Diagnostic Sleep Study ONLY - 95810                                | <input type="checkbox"/> BIPAP Titration- 95811; <b>FAILED CPAP, ADV. TITRATION</b>          |
| <input type="checkbox"/> SPLIT night Sleep Study – 95811                                    | <input type="checkbox"/> PAP Re-Titration- 95811; <b>2<sup>ND</sup> NIGHT TITRATION ONLY</b> |
| <input type="checkbox"/> CPAP Titration – 95811; <b>2<sup>ND</sup> NIGHT TITRATION ONLY</b> | <input type="checkbox"/> MSLT- 95805; <b>Preceded by PSG sleep study</b>                     |

**\* It is very important for the safety and comfort of the patient we know of any special needs they may have. Please have patient bring their medications and indicate whether patient has:**

Other Special Instructions/requests: \_\_\_\_\_

\_\_\_\_\_  
**Physician's Name**

\_\_\_\_\_  
**Phone/ Fax Number**

\_\_\_\_\_  
**Physician's Signature (Required)**

\_\_\_\_\_  
**Date/ Time (Required)**

\*\*\*CONFIDENTIALITY NOTICE\*\*\*

This document accompanying this telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled, unless otherwise required by state law. If you are not the intended recipient, you are hereby notified that any disclosure copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for return of these documents.