



Pediatric Sleep Study Referral

Email: JCHSleep.Referrals@easternhealth.ca Fax: 709-777-7420

Incomplete referrals will be returned



Name: _____

HCN: _____

Date of Birth: _____

This is a Level 3 polysomnogram indicated for investigation for sleep disordered breathing. This is not to investigate other sleep disorders or parasomnias.

Date of Request: DD/MONTH/YYYY

Parent/Guardian Name: _____

Address: _____ Telephone: _____

Family Physician: _____ Telephone: _____

Is an interpreter required to facilitate interactions? Yes No If Yes, language: _____

Has this patient seen ENT? Yes No If Yes, Date: DD/MONTH/YYYY

Referring Physician: Pediatrician ENT Other: _____

Reason for sleep study referral:

Test Requested:

Level 3 polysomnogram Overnight oximetry Transcutaneous CO₂ monitoring

Relevant past medical history:

Current Medications:

Pre-existing conditions (check all that apply):

- Previous upper airway surgery (provide details): _____
- Genetic syndrome - details: _____
- Craniofacial anomalies
- Obesity (BMI): _____
- Lung disease
- Neurological Disease
- Asthma
- Cardiac Disease

Referring Practitioner's Name: _____ Signature: _____ Date: DD/MONTH/YYYY

Telephone: _____

Submit Form

Administration Only:	
Date Referral Received: <u>DD/MONTH/YYYY</u>	Date of Appointment: <u>DD/MONTH/YYYY</u>
Date Parent/Guardian Contacted: <u>DD/MONTH/YYYY</u>	Priority Assigned: _____