ARNOLD PALMER HOSPITAL
For Children
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Pediatric Pulmonology Specialty Practice Sleep Disorders Clinic
1118 S. Orange Ave. • Orlando, Florida 32806 • 321.841.4921 • Fax: 407.425.6657

Patient Information:

Last Name _____ **First** Name _____

Date of Birth: (dd/mm/yy) _____ Sex _____

Address _____ City _____

Postal Code _____ Phone: H (_____) _____ W (_____) _____

Request Sleep Study:

_____ Full Sleep Study

_____ CPAP/BiPAP Sleep Study

_____ Full EEG Montage

Previous Sleep Studies ☐ No ☐ Yes

When _____(please provide copies)

Location _____

Current CPAP? Yes No CPAP Pressure_____

DME Vendor:_____

Indications for Sleep Lab Study

____ Snoring +/- apneas / fatigue (?sleep apnea syndrome)

____ Tonsillar hypertrophy

____ Overweight/ Obesity

____ Daytime sleepiness or hyperactivity

____ ADHD with restless or disturbed sleep

____ Other _____

Medical History/Sleep Complaint: **Age:** _____ **Height:** _____ **Weight:** _____ **BMI:**_____

_____

_____

Medications:

_____

_____

☐ **Request consultation with sleep study** **Request consultation only**

Referring Physician Information

Signature (required) _____

Name (print) _____

MD's Phone No. _____

MD's Fax No. _____

Date _____

For Office Use

Date Received _____ Clerk _____ Assigned ID_____

Physician Authorized_____Date_____Signature_____

PSG:_____CPAP:_____Other:_____Comments:_____