Arkansas Children's
HOSPITALS · RESEARCH · FOUNDATION

Arkansas Children's Hospital
Pediatric Sleep Disorders Center
Sleep Procedure Request Form

Patient Name:_____
Date of Birth:_____
Gender: **Female**_____ **Male**_____
Height: _____cm **Weight:** _____kg

SENSORY / BEHAVIOR: **Does the patient have *"ANY"* developmental, behavioral or sensory concerns?** ☐ Yes ☐ No

If yes, please list: _____

DIAGNOSES / INDICATIONS:

- ☐ **ADHD**
- ☐ Assess O2 Requirement
- ☐ **Autism**
- ☐ CCHS [Diagnosed]
- ☐ Craniofacial Abnormalities
- ☐ Delayed Sleep Phase
- ☐ **CPAP – AD Program**
- ☐ **Down Syndrome**
- ☐ GERD
- ☐ Hypersomnolence
- ☐ Insomnia / Difficulty Sleeping
- ☐ Neuromuscular Diseases
- ☐ Nocturnal Seizures
- ☐ **S/P Surgical Intervention** [list]_____
- ☐ Obstructive Sleep Apnea [Diagnosed]
- ☐ Periodic Limb Movement
- ☐ Parasomnia
- ☐ **Sensory Issues**
- ☐ Sleep Disordered Breathing
- ☐ Suspected CCHS
- ☐ **All Other Diagnoses:** _____

SYMPTOMS / FINDINGS:

- ☐ Bruxism
- ☐ Behavioral/School Problems
- ☐ Cataplexy
- ☐ Excessive Daytime Somnolence
- ☐ Jerking During Sleep
- ☐ Laryngomalacia / Stridor
- ☐ Morning Headaches
- ☐ Mouth Breathing
- ☐ Night Terrors
- ☐ Nocturnal Enuresis
- ☐ Restless Legs
- ☐ Restless Sleep
- ☐ Obesity
- ☐ Other_____
- ☐ Sleepwalking
- ☐ Sleeptalking
- ☐ Snoring
- ☐ Tonsillar Hypertrophy
- ☐ Movement Disorder
- ☐ Witnessed Apneas

TONSILS: ☐ None ☐ Normal ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+

SPECIAL NEEDS:

- ☐ Oxygen @ _____lpm
- ☐ CPAP @ _____cm H_2O
- ☐ BPAP @ _____cm H_2O
- ☐ Feeding Pump
- ☐ Trach Capped
- ☐ Trach Uncapped
- ☐ Rate_____bpm
- ☐ Lift
- ☐ Ventilator Dependent
- ☐ Visually / Hearing-Impaired
- ☐ Non-Ambulatory / Wheelchair
- ☐ Other:_____
- ☐ G-Button
- ☐ VP Shunt
- ☐ Interpreter

SLEEP TEST ORDERED:

- ☐ PSG - Full-Night – No Intervention
- ☐ PSG - Full-Night – Possible Intervention
- ☐ PSG - CPAP Titration
- ☐ PSG - O2 Titration
- ☐ Multiple Sleep Latency Test [MSLT]
- ☐ Maintenance of Wakefulness Test [MWT]
- ☐ PSG - BPAP Titration
- ☐ PSG - Trach-Capped Protocol
- ☐ Additional Instructions: _____

ORDERING PHYSICIAN - SIGNATURE: _____ **DATE:**_____

ORDERING PHYSICIAN - PRINTED NAME:_____

SLEEP CENTER STAFF USE ONLY:

Documents Reviewed: ☐ History & Physical ☐ Recent Clinic Notes ☐ Sleep Questionnaire ☐ Sleep Diary ☐ EPIC Notes

Tech Reviewer [Please Sign]:_____ Date Reviewed:_____

Physician/LIP Reviewer [Please Sign]:_____ **Date Reviewed**:_____