CHEO Respirology – Sleep Clinic Referral

- The focus of the CHEO respirology sleep laboratory at present is the evaluation of complex respiratory problems. Sleep study has limited value in the evaluation of behavioral disorders, such as insomnia**. At present we are not evaluating otherwise healthy children with sleep related behavioral disorders.**

- **In order to help us best prioritize and best serve the needs of your patients, all parts of this form must be completed.**

Date of Referral _____

Referring MD: _____ Signature_____

Address: _____ Phone/Fax: _____

Patient Name:_____ CHEO M.R.N. #:_____ DOB: _____

Gender: □Male □Female □Transmale □Transfemale □Non binary/gender fluid □Two-Spirit □Agender

Height:_____cm Weight:_____ kg Date of height and weight: _____

Home Phone:_____ Cell Phone:_____

Primary Physician:_____

Primary question to be answered by the sleep study:_____

Current medications:_____

Special equipment or needs: Wheelchair / G-tube / Other (please specify)_____

Pre-existing Medical Conditions (Please specify if yes to any of the questions below):

□Genetic syndrome
□Craniofacial anomalies
□Neuromuscular disease
□Obesity
□Lung disease
□Neurological disorder
□Asthma
□Cardiac disease
□Behavioral concern (e.g. ADD/ADHD)
□Mental health (e.g. anxiety, depression)
□Autism spectrum disorder
□Developmental Delay

Brief medical history:
_____
_____
_____

Did the patient have adenotonsillectomy or airway surgery? □ No □ Yes If yes, please specify the type and the date
_____

CHEO

INDICATIONS FOR STUDY:
□Snoring (>3 nights/week) □Observed apneas >10 seconds □Gasping
□Obstructive Sleep Apnea □Central Sleep Apnea □Hypoventilation
□Other_____

Patient's Symptoms/Physical Exam (CHECK ALL THAT APPLY):

Nocturnal Symptoms:
□ Difficulty breathing □ Snoring or noisy breathing □ Observed apnea
□ Restlessness □ Sweating □ Gasping for air
□ Choking □ Cyanosis or pallor □ Sitting upright to sleep/neck hyperextension asleep
□ Bedwetting (secondary, not primary)
□ Other _____

Daytime Symptoms:
□ Irritability □ Excessive somnolence □ Mouth breathing
□ Frequent pharyngitis □ Poor school performance □ Weakness/fatigue
□ Other _____

Physical Examination Finding:
□ Tonsillar hypertrophy (Tonsil size_____) □ Adenoid hypertrophy □ Obesity (BMI: ___)
□ Allergic rhinitis □ Nasal congestion □ Failure to thrive

Bed time:_____ Wake time:_____

Previous Tests and Interventions:
Has patient previously been tested in our lab? □no □yes If yes, what test _____ Date_____
Has patient previously had an overnight oximetry or a home sleep test? □ no □ yes If yes, what test _____ Date_____ Result: _____
Is patient on oxygen at home? □ no □ yes If yes, method_____ quantity_____

Is patient on CPAP/BPAP at home? □ no □ yes If yes, settings_____

Is patient on invasive ventilation via tracheostomy at home? □ no □ yes If yes, settings_____

Does patient have tracheostomy? □ no □ yes If yes, type and size of tracheostomy _____