Provider Pediatric Referral Form

breathoflife • sleepmedicine

Patient Information

Name | DOB

Guardian

Name | DOB

Relationship to patient

Contact

Email | Phone

Mailing address | Zip code

Ins. 1

Primary insurance name

ID# | Group#

Ins. 2

Secondary insurance name

ID# | Group#

Reason For Referral *(select all that apply)*

- ☐ Snoring / witnessed apneas / gasping
- ☐ Mouth breathing *sleep / wake*
- ☐ Restless sleep / frequent awakenings
- ☐ Excessive daytime sleepiness
- ☐ Craniofacial / airway concerns *(e.g., high palate, retrognathia, macroglossia)*
- ☐ Neurobehavioral concerns *(e.g., ADHD, learning difficulties, mood)*
- ☐ Persistent OSA symptoms post-adenotonsillectomy
- ☐ PAP therapy evaluation / management
- ☐ Symptomatic Anklyoglossia
- ☐ Other *please describe in Clinical Notes*

Relevant History *(select all that apply)*

Height | Weight

Syndromes / Genetics

- ☐ Down syndrome *Trisomy 21*
- ☐ Craniofacial syndrome *please describe in Clinical Notes*
- ☐ Other *please describe in Clinical Notes*

ENT / Pulmonlogy

- ☐ Prior T&A *please include date in Clinical Notes*
- ☐ Asthma / reactive airway
- ☐ Chronic nasal congestion / Rhinitis

Neurology / Development

- ☐ Autism Spectrum Disorder
- ☐ Seizure Disorder
- ☐ Hypotonia / Neuromuscular Disorder

Relevant Medications

Clinical Notes

Items to Include

Please include the following items when submitting the referral form.

- Patient face sheet / demographics page
- Copy of the patient's insurance card(s) front and back
- Insurance authorization *(if required)*
- Copy of valid photo ID
- Relevant medical records, sleep studies, PAP download, echocardiogram, medication list, recent clinic notes

Referring Provider

Name | ☐ Phone

☐ Email | ☐ Fax

Referring provider signature | Date

breathoflife • sleepmedicine

Address 1717 Lincoln Way STE 201 CDA ID 83814 **Phone** 208.758.9699

Email info@drsleepmed.com **Fax** 208.758.8535