Sleep Medicine Department
Kapi'olani Medical Center for Women & Children | Hawai'i Pacific Health
1319 Punahou Street
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Ph:(808) 983-8626 option 1 | Fax:(808) 983-8710

PEDIATRIC SLEEP CENTER REFERRAL REQUEST

TODAY'S DATE:_____

PATIENT NAME:_____

GUARDIAN NAME: _____

GUARDIAN RELATIONSHIP: _____

PHONE:_____

SEX: _____ DOB: _____

ADDRESS:_____

CITY: _____ STATE:_____

ZIP:_____

Primary Insurance:_____

Policy #:_____

Secondary Insurance: _____

Policy #:_____

Prior-Auth: _____ Requested _____ Not required

Authorization #: _____

Diagnosis Code(s): _____

_____

_____

CONSULT and TESTS

❑ Sleep Consultation for diagnostic testing, treatment and follow up (Required with exceptions for Pediatric Pulmonary/ENT/Neurology referrals)

❑ Diagnostic In-Lab Polysomnogram (PSG)

❑ Split-Night In-Lab PSG *CPAP started if indicated*

❑ Positive Airway Pressure (PAP) Titration Study

❑ Polysomnogram diagnostic with seizure montage

❑ Multiple Sleep Latency Test (MSLT)

❑ Ventilator/NIPPV Titration (ordered only by Pulmonary)

Current Settings: _____

_____

SPECIAL NEEDS

❑ Primary Language Spoken _____

❑ Fall Risk ❑ Mentally Impaired

❑ Other _____

URGENCY

❑ Not Urgent ❑ Urgent due to:_____

SIGNS/SYMPTOMS and MEDICAL CONDITIONS

Please check all that apply

❑ ADHD	❑ ALTE
❑ Asthma	❑ BPD
❑ Craniofacial Disorder	❑ Cystic Fibrosis
❑ Daytime Hypersomnolence	❑ Down Syndrome
❑ Enuresis	❑ Hypertrophic tonsils/adenoids
❑ Nocturnal Hypoxia	❑ Myelomeningocele
❑ Narcolepsy	❑ Observed choking/gasping
❑ Nocturnal Arousals	❑ Obesity BMI _____
❑ Observed Apnea	❑ Prader-Willi Syndrome
❑ Pulmonary Hypertension	❑ Snoring
❑ Seizures	❑ Other _____

PRIOR SLEEP STUDY *Please send report if available*

❑ No ❑ Yes

Study Date: _____

Please fax completed request to (808) 983-8710

Attach H&P and any other supporting documentation

REFERRING PROVIDER: _____

PHONE:_____ FAX:_____

SIGNATURE: _____

DATE:_____ TIME:_____