London Health Sciences Centre | Children's Hospital London Health Sciences Centre

Paediatric Sleep Lab Referral Form
300 Commissioners Rd E, London, ON N6A5W9
Tel: 519-685-8500 x56642 Fax: 519-685-8156

The focus of the sleep laboratory at present is the evaluation of complex respiratory and neurological problems. Sleep study has limited value in the evaluation of behavioural disorders, such as insomnia. We are presently not evaluating otherwise healthy children with sleep-related behavioural disorders. Please print and provide complete information to avoid delays and to assist in prioritizing patients.

DATE OF REFERRAL:______________________________

PATIENT IDENTIFICATION:
Name:______________________________________ HCN: ____
DOB (yy/mm/dd):____________________ Sex: ______ Interpreter required: ☐ No ☐ Yes, Language spoken:_________
Address: ____
Parent/guardian name: _______________________________ Home #: _____________________________________
Alternate #: ____

REQUESTED SERVICE: Pease note, patients will be triaged to lab or clinic on the basis of the information provided.
☐ Consultation and sleep study as required ☐ Sleep study only
☐ Urgent (please explain):____

REASON FOR REFERRAL (please include medical diagnoses/medical history):
____
____

CHECK ALL THAT APPLY:

NOCTURNAL SYMPTOMS:		DAYTIME SYMPTOMS/SIGNS:		DIAGNOSES:	
☐ Snoring/Noisy resp	☐ Cyanosis	☐ Excessive sleepiness	☐ Fatigue	☐ Craniofacial abn	☐ Obesity
☐ Pauses/Apnea	☐ Gasping	☐ Irritability	☐ Hyperactivity	☐ Seizure/Epilepsy	☐ ADHD
☐ Mouth breathing	☐ Choking	☐ Poor concentration	☐ Anxiety	☐ Cerebral palsy	☐ Arrythmia
☐ Morning headache	☐ Seizure	☐ Poor school performance		☐ Congenital Heart Dz	☐ BPD
☐ Limb Movements	☐ Awakenings	☐ Enlarged tonsils / adenoids		☐ Neuromuscular Dz	☐ Asthma
☐ Restless sleep	☐ Enuresis	☐ Family Hx of sleep disordered breathing		☐ Prader-Willi	☐ Trisomy-21
Other: ____________		Other:____________		Other:____________	

PAST MEDICAL HISTORY:
Medications: ____
BMI: _____________ Allergies: ____
Tonsils removed: ☐ No ☐ Yes, when:______ Adenoids removed: ☐ No ☐ Yes, when:_____
ENT following: ☐ No ☐ Yes, who:________________________ Other physicians involved in care: ____________________
Previous sleep study: ☐ No ☐ Yes, when:______ . If yes: ☐ LHSC ☐ Elsewhere (please include a copy of the report)
Is the patient on oxygen: ☐ No ☐ Yes, How much__________ What method___________________________
Does the patient sleep with respiratory technology: ☐ None OR Yes - ☐ CPAP ☐ BiPAP ☐ Invasive-Ventilation

If yes: Mode:_______ Settings (IPAP, EPAP,Rate):__________________________________ Interface:____________

REFERRING MD:_____________________________________ **SIGNATURE:**_____________________________
BILLING NUMBER:_____________ **FAX:**_______________ **ADDRESS:**_________________________________

OFFICE USE ONLY:

TRIAGE	LOCATION	STAFFING LAB	STUDY TYPE
□URGENT	□Clinic	□Routine	□Baseline
□Semi-Urgent	□Lab	□Complex Resp	□CPAP □BiPAP
□Routine	□Clinic or Lab	□Complex Med/Behav	□ O2 □Split
		□Requires 1:1	□MSLT