The Children's Hospital of Philadelphia
THE SLEEP LABORATORY
POLYSOMNOGRAM REQUEST FORM

❑ Outpatient Study date: _____

Name:_____ M.R. #:_____ DOB:_____ Sex: M / F

Ht/Wt:_____cm _____kg Home Phone:_____ Cell Phone:_____

Primary Physician:_____

Diagnosis:_____

Requesting Physician:_____(Non-divisional) Phone / Fax:_____

Address: _____

ALTERNATE CONTACT FOR CRITICAL RESULTS: _____ _Phone / Fax _____

INDICATIONS FOR STUDY:

❑ Obstructive Sleep Apnea ❑ Central Sleep Apnea ❑ Hypoventilation ❑ Insomnia

❑ Other_____

Patient previously been tested in our lab? ❑no ❑yes If yes, what test _____ date_____

Is patient on oxygen at home? ❑ no ❑ yes If yes, method_____ quantity_____

Current medications_____ Special equipment or needs _____

Brief medical history: _____

_____

CHECK ALL THAT APPLY:

Nocturnal Symptoms:

_____Difficulty breathing _____Snoring or noisy breathing _____Observed apnea
_____Restlessness _____Sweating _____Gasping for air
_____Choking _____Cyanosis or pallor _____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

_____Restrictive lung disease _____Obstructive lung disease _____Respiratory muscle weakness

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❑Baseline

Ordering Physician/Clinician's Signature_____

Most recent typed office note and critical contact MUST be attached/ entered or study cannot be scheduled.

Please fax to the Sleep Lab (215) 590-2632