UB|MD PEDIATRICS

JOHN R. OISHEI Children's Hospital

UBMD PEDIATRICS SLEEP CENTER

T: 716.323.0370 | F: 716.323.0296

Pediatric Sleep Medicine Clinic

Conventus
1001 Main Street, 4th Floor
Buffalo, NY 14203

University Commons
1404 Sweet Home Road, Suite 5
Amherst, NY 14228

Pediatric Sleep Lab

Oishei Children's Hospital
818 Ellicott Street, 2nd Floor
Buffalo, NY 14203

REFERRAL REQUEST

PLEASE COMPLETE ALL OF THE FOLLOWING: Date: _____

Referring Provider

Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

SLEEP STUDY REQUESTED (IF APPLICABLE)

- ☐ Polysomnography
- ☐ CPAP/BiPAP/AVAPS Titration
- ☐ Oxygen Titration
- ☐ Decannulation Protocol
- ☐ Multiple Sleep Latency Testing
- ☐ Maintenance of Wakefulness Testing
- ☐ Other: _____

SERVICE REQUESTED

- ☐ Clinic visit with the Sleep Medicine Providers (All referrals for sleep studies are to be seen in clinic first)
- ☐ Sleep study only, management and sleep study follow-up will be by ENT provider: _____

PATIENT DEMOGRAPHICS (PLEASE COMPLETE ALL INFORMATION)

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Parent/Guardian Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work/Cell: _____

INSURANCE

Primary Insurance: _____ Subscriber: _____

ID #: _____ DOB: _____ Insurance Verification/Referral Attached? Y N

Secondary Insurance: _____ Subscriber: _____

ID #: _____

REASON FOR REFERRAL

- ☐ Poor quality/restless sleep
- ☐ Excessive sleepiness
- ☐ Loud snoring, frequent awakenings
- ☐ Night time behaviors (walking, nightmares, etc.)
- ☐ History of sleep apnea
- ☐ Other: _____

SIGNIFICANT PMH/SH (ATTACH NOTES)

Epworth Sleepiness Scale: _____

Neck circumference: _____ Tonsillectomy/Adenoidectomy Date: _____

Sleep aids tried/in use: _____

Signature of Referring Physician: _____

Partnered with Sleep & Wellness Centers