Santa Monica
SleepDisordersCenter
at St. John's Medical Plaza
Daniel Norman, M.D., Medical Director
Paul B. Haberman, M.D.
Diplomates, American Board of Sleep Medicine

1301 Twentieth St., Suite 370
Santa Monica, CA 90404

Tel: (310) 828-2293
Fax: (310) 453-3759

PEDIATRIC SLEEP SERVICES REFERRAL FORM

Thank you for referring your patient to Santa Monica Sleep Disorders Center. Please provide the following information and pertinent medical records so that we can provide the best and most timely service.

Referring Physician: _____ **Ph:** _____ **Fax#**:_____ _____

Patient's Name: _____ **D.O.B**._____ **Ph.**:_____

Parent/Guarantor Name:_____

Address: _____ **City**: _____ **Zip code**:_____

Services requested– check box (es):

CONSULT REQUEST:
- □ Sleep Specialist Consultation - testing will be recommended only if / when appropriate
- □ Following Sleep Study Requested Below

TESTING REQUEST:
- □ **Lab-Based Polysomnography**: an attended sleep study performed as:
  - □ baseline testing
  - □ to assess response to □ Tonsillectomy □ other therapy _____
  - □ baseline followed by MSLT (for patients suspected of having narcolepsy)

Clinical Diagnosis (please check one): □ Obstructive Sleep Apnea □ Narcolepsy □ Other: _____

Signs & Symptoms

□ Snoring □ Observed apnea during sleep □ Attention Deficit □ Hyperactivity

□ Obesity □ Excessive daytime sleepiness □Inappropriate daytime napping □ Sleepiness that interferes w/daily activities

□ Habitual snoring or, gasping/choking episodes associated with awakenings □ Enuresis □ Down 's Syndrome

□ Unexplained hypertension □ Soft tissue abnormalities or neuromuscular diseases involving the craniofacial area or upper airway

Doctor's Signature: _____ **Date:**_____

***Please fax a demographic "face sheet" with most recent clinic note, and insurance information** (if available).

Thank you for the referral!