



Pediatric Sleep Center Referral Form

Phone: 414.266.2790 • Fax: 414.266.3421

Date: \_\_\_\_\_

Thank you for referring your patient to the Sleep Center. Please provide the following information and pertinent medical records so that we can provide the best and most timely service. The Sleep Center physician will review this information and a member of the team will contact the family regarding the referral. If the child is not appropriate for referral, you will be contacted. Please call 414-266-2790 if you have questions or wish to speak with a Sleep Center Physician.

Your patient has an appointment scheduled with \_\_\_\_\_ for the first time on \_\_\_\_\_.

Patient Information and Referring Provider Information section with fields for names, addresses, phone numbers, and insurance.

- Reason for referral (Please describe chief complaint): Snoring, Obstructive apneas, Central apneas, Other, Daytime sleepiness, Insomnia (teens), Difficulty sleeping (children), Nightmares, Night terrors, Sleep walking, Enuresis.

Pertinent past medical history: (Please attach recent clinic visit notes)

Evaluation that has already been completed: (Please include copies of prior sleep studies)

\*\* Please fax this form to 414-266-3421 along with pertinent medical records. Please include any necessary insurance referral authorizations. Thank you.

Referring Provider Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

OFFICE USE ONLY section with fields for Date Received, Clinic, Sleep Study, Referral status, and Notes.

Additional copies of this form can be found at www.chw.org

APPLY DT BARCODE STICKER MD Referral Accepted DT 346 MD Referral Denied DT 9901

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4