Clear Form

Children's Hospital of Wisconsin®

A member of Children's Hospital and Health System.

Pediatric Sleep Center Referral Form

Phone: 414.266.2790 • Fax: 414.266.3421

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

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

Patient Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Patient Address: _____

_____

Home Phone Number: _____

Work Phone Number: _____

Insurance Carrier: _____

Needs Referral: ☐ Yes ☐ No

Referring Provider Information

Provider Name: _____

Provider Address: _____

_____

Phone Number: _____

Fax Number: _____

Reason for referral (Please describe chief complaint):

☐ Snoring ☐ Daytime sleepiness ☐ Nightmares ☐ Sleep walking

☐ Obstructive apneas ☐ Insomnia (teens) ☐ Night terrors ☐ Enuresis

☐ Central apneas ☐ Difficulty sleeping (children)

☐ Other _____

_____

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

Date Received: _____ Clinic: _____ Sleep Study: _____

☐ Referral Accepted Date of Appointment: _____

☐ Referral Denied Reason: _____

Referral status communicated to _____ on _____ /_____ / _____

Notes: _____

_____

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

Print Form

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