Sleep Clinic Referral Form

Sleep Disorders Center

We know children.

Thank you for referring your patient to the Sleep Disorders Center. Please fax the following information so we can provide the best and most timely service as a member of the Sleep Team will contact the family for scheduling:

- most recent H&P and/or clinic note on the patient you are referring
- insurance & demographic information

fax to: 402-955-3693

Today's Date: _____

Patient Name: _____

Date of birth: _____

Parent/Guardian Name: _____

Referring Provider: _____

Provider Specialty: _____

Phone: _____

Fax: _____

Primary Care Physcian: _____

REFERRAL FOR MEDICAL SLEEP CLINIC

- ☐ CPAP Management
- ☐ Neuromuscular problems
- ☐ Periodic limb movements
- ☐ Other (comments) _____
- ☐ Narcolepsy
- ☐ Sleep apnea concerns
- ☐ Restless sleep problems

REFERRAL FOR BEHAVIORAL SLEEP CLINIC

- ☐ Anxiety/behavioral related sleep problems
- ☐ Circadian rhythm problems
- ☐ CPAP adherence problems
- ☐ Head banging
- ☐ Other (comments) _____
- ☐ Bedwetting
- ☐ Body rocking
- ☐ Insomnia
- ☐ Nightmares

Provider Signature/Date: _____

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