



Texas Children's Hospital
www.texaschildrenshospital.org

Texas Children's Referral Form

Texas Children's Sleep Center
Phone: 832-826-2156 Fax: 832-825-6022

Sleep Study Order Form (Please check one): _____

Date Requested: _____

- Sleep Study
- Sleep Center Clinic Evaluation

Last Name	First Name	MI	Sex (M/F)	Date of Birth

Street Address	City	State	Zip Code

Parent/Guardian(s) Name

Home Phone #	Mother's Work	Father's Work

Referring Physician Name:	Contact Person:	Contact Number:

Phone:	Fax:	E-mail:

If a translator is needed, what language?

Reason for Exam: (Check all that apply)
(Check a minimum of one)

- Central Sleep Apnea
- Hypoventilation
- Obstructive Sleep Apnea
- PAP Titration
- Parasomnias
- pH Probe (on/off acid blocker)
- Seizures
- Sleepiness
- Snoring

Current Treatment (CPAP/BiPAP): (Check all that apply)

- BiPAP
- CPAP
- Mechanical Ventilation (provide settings)
- Oxygen
- None

Medical Conditions: (Check all that apply)
(Check a minimum of one)

- Chronic Lung Disease
- Combative Patient
- Developmentally Delayed
- Mechanical Ventilation
- Neuromuscular Disease
- Pulmonary Hypertension
- Tracheostomy
- No Additional medical conditions
- Other- Please Comment: _____

For pH Probe Sleep Study: (Check all that apply)

- On Acid Blocker
- Off Acid Blocker
- BMI

Attending Provider Name (Must have): _____