OU Medical Center
SLEEP DISORDERS CENTER

The Children's Hospital at OU Medical Center

PEDIATRIC ORDER FORM
OUMC SLEEP DISORDERS CENTER 2015

A. Patient Information

Patient Name: _____ Patient DOB:_____ Age (years): _____

Parent/Guardian Name: _____ Daytime Phone:_____ Evening Phone: _____

SoonerCare/Medicaid # (if applicable) _____

B. Medical/Sleep History/Symptoms/Diagnosis (check all that are appropriate)

	Restless Sleep		Apnea		ADHD
	Snoring		Leg cramps, movements/jerks		Arrhythmia (specify): _____
	Tonsils enlarged		Parasomnias (e.g. night terrors, sleep walking)		Other (specify):_____

	C. Study Requested (please check one)	Conditions
	PSG/Diagnostic Sleep Study (95782 or 95810)	95782: 0-5 years of age 95810: 6 years of age and older
	CPAP Titration (95783 or 95811)	Previous study date: _____ 95783: 0-5 years of age 95811: 6 years of age and older **REQUIRES MEDICAL DIRECTOR APPROVAL**
	Other (Please specify) _____	

D. The following documents **must** be provided by the referring physician for **all** patients:

- ☐ H&P (must be within the last 6 months) to include special needs (wheelchair, oxygen, feeding tubes)
- ☐ Demographics sheet
- ☐ Recent copy of insurance information

E. Would you like us to obtain the prior authorization? ☐YES (see below) ☐NO ☐N/A

If you answered yes, the following must be provided by the referring physician:

- ☐ Sleep history
- ☐ Physical exam of the airway

F. Referring Physician Information

Requesting Physician Name: _____ NPI #: _____

SoonerCare#:_____ Phone: _____ Fax: _____

Attending Physician Name (if different): _____ NPI #: _____

PCP Name: _____ Phone: _____ Fax:_____

Clinic Contact Name*: _____ Phone: _____ Fax: _____

(*contact at referring clinic for questions and fax number for all sleep study information)

Requesting Physician Signature: _____ Date/Time: _____

Please fax all information to 405-271-6690
Please refer questions to 405-271-5605

OFFICE USE ONLY

Date Fax Received _____ **Date of Appointment** _____
Date Physician Notified _____ **Date Parents Notified** _____
Approved _____ **Denied** _____ **Signature of Medical Director** _____

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Sleep History and Physical Exam of Airway Form

For your convenience, this form may be used to meet our documentation requirements (listed in Section E of the order form) for Prior Authorization submission to SoonerCare.

1. SLEEP HISTORY

Family reports positive history of (check all that apply):

- ☐ Snoring-described as:
  - □ Extremely loud
  - □ Moderately loud
  - □ Soft
  - □ Occurring intermittently
  - □ Occurring frequently
- ☐ Restless sleep
- ☐ Frequent sleep arousals
- ☐ Witnessed apnea
- ☐ Bedwetting
- ☐ Hyperactivity
- ☐ Daytime hypersomnolence
- ☐ Aggressive behavior
- ☐ Poor academic performance
- ☐ Fear of bedtime
- ☐ Mouth breathing
- ☐ Recurrent tonsillar infections
- ☐ Morning headaches
- ☐ Nocturnal gasping

2. PHYSICAL EXAM OF THE AIRWAY

Circle the appropriate findings:

Nasal Cavity

- **External:** normal, abnormal, bilateral symmetry, asymmetric, traumatic deviation to the right, traumatic deviation to the left, tissue edema, closed nasal fracture
- **Mucosa:** moist, dry, pale, edematous, erythematous
- **Septum:** non deviated, deviated to the left, deviated to the right, septal spur – right, septal spur – left, valve collapse, perforation
- **Turbinates**: normal, hypertrophied to the right, hypertrophied to the left, hypertrophied bilaterally
- **Nasal Secretion**: clear/minimal, mucoid, purulent, thick, copious

Oral Cavity

- **Mucosa:** pink and moist, abnormal
- **Tongue**: normal, macroglossia, ankyloglossia
- **Palate**: normal palatal elevation, cleft palate, abnormal
- **Dentition**: normal for age, poor, caps present
- **Oral lesions:** none noted, present
- **Trismus:** none, present

Oropharynx

- **Mucosa:** normal, positive for cobblestoning
- **Tonsils:** 1+, 2+, 3+, 4+, no tonsillar edema, well healed tonsillar fossa