Hôpital de Montréal pour enfants
Centre universitaire de santé McGill

Montreal Children's Hospital
McGill University Health Centre

Patient Name
MRN#
RAMQ#

FMU-6711

Medical consultation/Medical order

PEDIATRIC SLEEP MEDICINE

MUHC use only

Date referral received (YYYY/MM/DD):

IN ORDER TO ASSESS THE URGENCY OF THE REFERRAL AND PRIORITIZE APPOINTMENTS, ALL PARTS OF THIS FORM MUST BE COMPLETED. INCOMPLETE FORMS WILL BE RETURNED.

Cellular No. for patient/parent:

Email for patient/parent:

☐ Nocturnal home oximetry with a medical consultation	☐ Polysomnography with a medical consultation	☐ Medical Consultation for a suspected sleep disorder

☐ **Next available appointment**	☐ **Urgent** (pls. explain)	☐ **Semi-urgent** (pls. explain)

Referring Physician (in printed letters):	License No.:	Signature:	Date: YYYY/MM/DD
Email:	Telephone:	Fax:	

Reason for referral

☐ R/O Obstructive sleep apnea ☐ Other:

NOTES:

Nocturnal Symptoms

☐ Snoring or noisy breathing
☐ Respiratory pauses/witnessed apneas
☐ Gasping/struggling to breathe at night
☐ Frequent awakenings/nocturnal arousals
☐ Secondary enuresis
☐ Cyanosis
☐ Sweating

Daytime Symptoms

☐ Excessive somnolence
☐ Morning headaches
☐ Mouth breathing
☐ Poor concentration
☐ Poor school performance

Other

Video description of child sleeping (if available):

Pre-existing medical condition (s):

☐ Tonsillectomy+/-Adenoidectomy ***planned***? ☐ ***No*** ☐ ***Yes***

☐ Nasal steroids ☐ ***No*** ☐ ***Yes,*** *since when:* _____

Results of physical exam (done by the referring physician)

☐ Tonsillar Hypertrophy
☐ 0 ☐ 1+ ☐ 2+ ☐ 3 ☐ 4+

☐ Obesity

☐ ***Previous*** Tonsillectomy:
☐ ***Yes,*** *when:* _____ ☐ ***No*** ☐ ***Unknown***

☐ Adenoidal Hypertrophy
☐ ***Yes*** ☐ ***No*** ☐ ***Suspected*** ☐ ***Unsure***

☐ ***Previous*** Adenoidectomy:
☐ ***Yes,*** *when:* _____ ☐ ***No*** ☐ ***Unknown***

Internal use only (Sleep clinic/Sleep lab)

☐ Nocturnal home oximetry:
☐ R/A ☐ CPAP ☐ BPAP ☐ HFNC ___lpm ☐ O_2 ___lpm

☐ Home PSG:
☐ with EEGs ☐ with PLM protocol

☐ PSG (diagnostic)

☐ PSG CardioResp: ☐ with EEGs ☐ with PLM

☐ New consultation visit

☐ PSG (therapeutic): ☐ CPAP ☐ BPAP ☐ HFNC ___lpm ☐ O_2 ___lpm

☐ MSLT ☐ Actiwatch

Reason for return of referral:
☐ Demographic info missing
☐ Clinical info missing
☐ Pt does not meet criteria
☐ Illegible
☐ Redirected outside of MUHC
☐ Impossible to contact family

Physician ((in printed letters)	**License No.**	**Signature**	**Date** (YYYY/MM/DD)

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