

Alberta **Children's** Hospital

Pediatric Sleep Service Referral
Phone: 403-955-7563 Fax: 403-955-7527

Referral date:

Referring physician:
Phone #:
Fax #:

Parent/guardian names:
Parent contact phone number:
Parent email:

Referral for: OSA: OSA & Sleep Behaviors: Sleep Behaviors: Insomnia:

Tonsils Removed: When: _____ **Adenoids Removed:** When: _____

Referred to ENT: Yes: No: *Dual referrals to ACH ENT/Sleep will be seen by **ENT first.**

******Please note: The Sleep Service does not accept direct referrals for Polysomnograms as we are not an open lab. This referral is to the Sleep Service and a PSG may be done as part of the sleep physicians recommendations******

The Sleep Service appreciates this information to allow appropriate and timely triaging of your patient!

Primary concerns:

- | | |
|-------------------------------|---|
| <input type="radio"/> Snoring | <input type="radio"/> Restless |
| <input type="radio"/> Pauses | <input type="radio"/> Daytime sleepiness despite sufficient sleep |
| <input type="radio"/> Fatigue | <input type="radio"/> Current hours of sleep per night _____ |

Behaviors:

- | | |
|---|---|
| <input type="radio"/> Hours per day of electronic use _____ | <input type="radio"/> Difficulty falling asleep |
| <input type="radio"/> Waking at night | <input type="radio"/> Difficulty staying asleep |

Sleep Hygiene techniques implemented:

- | | |
|---|---|
| <input type="radio"/> Consistent bedtime and waking routine | <input type="radio"/> Current Psychosocial services available to family i.e. another ACH clinic. If so, which clinic _____ |
| <input type="radio"/> Limiting of electronic use | |
| <input type="radio"/> Sleep hygiene discussed and/or information provided to family | <input type="radio"/> Referral submitted to community agency/Access Mental Health/EAP for sleep hygiene/behavior/mental health intervention. Please specify _____ |

To assist with triaging this referral, a two week sleep log is helpful, but not necessary for referral acceptance.

- Sleep Log attached

Please include any additional medical information or concerns: