Pulmonary Associates of Stamford

Pediatric Sleep Consultation Form

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Name Age Sex Primary MD Consult Req from:

History of Present Illness Date

Questions	Yes/No or best guess	Doctors Comments Only
1. What time is dinnertime?		
2. What time is bedtime? Weekdays? Weekends?		
3. What time is "out-of bed time"? Weekdays? Weekends?		
4. What are the approximate times for meals and/or bottles?		
5. How long does it take for the child to fall asleep?		
6. How many times does the child wake at night?		
7. How long does the child stay awake each time you get up at night?		
8. Does the child take naps?		
9. What time are the naps?		
10. In a 24-hr period how many hours does the child spend in bed?		
11. In a 24-hr period how many hours does the sleep?		
12. Is the child's bedroom quiet and comfortable?		
13. Does the child have her/his own room?		
14. Is there a computer, TV or radio in the room?		
15. Does the child snore?		
16. Does the child make choking sounds?		
17. Does the child stop breathing at night?		
18. Does the child work hard to breath?		
19. Does the child move a lot while sleeping?		
20. Does the child walk in her sleep?		
21. Does the child wake up screaming at night?		
22. Is bed wetting a problem?		
23. Does the child appear sleepy in the morning or during the day?		
24. Has the child ever become suddenly weak during laughing or other emotional times?		
25. Has the child ever complained about seeing things when going to sleep or waking?		
26. Has the child ever complained about not being able to move when going to sleep or waking?		
27. Has the child had problems in school or day care?		
28. Has the child had behavioral problems at home?		
29. Does the child drink any caffeine containing beverages (for example Coke, Ice Tea, Root Beer)?		

30. Does anyone smoke in the house?		
31. What time does Dad get home?		
32. What time does Mom get home?		
33. What's Mom's job?		
34. What's Dad's job?		
35. How long has the problem been going on?		
36. Are there any family problems?		
37. Has the child ever had a sleep study before?		

Please describe the families' activities after supper time:

What do you do if your child wakes up in the middle of the night or has trouble falling asleep:

Please describe what you think is the biggest problem with your child's sleep:

Please describe things you have tried to make the situation better:

Please list any medications including herbal preparations and vitamins

Please list any serious illnesses that brothers, sisters, Mom or Dad have:

Please list any illnesses or surgeries that the child has had:

Please list any allergies including medication, food or seasonal:

Please describe any problems during pregnancy or child birth or problems that occurred in the first year:

Has the child had any of these problems (circle those that apply):

Weight Change	Developmental problems	Frequent nausea, vomiting, diarrhea
Learning Disabilities	Small for Age	Nasal Congestion
Difficulty in School	Large for Age	Trouble Breathing
Difficulty Playing with Others	Headaches	Lack of Energy
Attention Deficit Disorder		

Please describe any other problems your child has

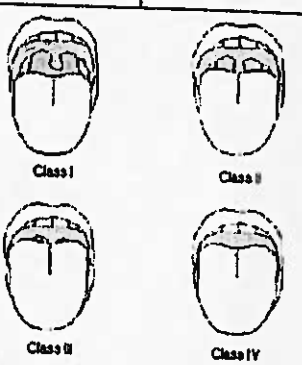
Physician Notes

EXAM

		Check if none apply
General		_acutely ill _chronically ill _cachectic _obese _dyspneic with walking _dyspneic at rest _frequent coughing _frequent throat clearing
Vital Signs		BP HR RR Wt Ht
ENT		_septal deviation _thrush _edentulous _poor dentition _inflamed nasal mucosa _dry buccal mucosa _"crowded" post pharynx _large uvula _low lying soft palate
Neck		_trachea not midline _thyroid nodule _diffuse thyromegaly _JVD _neck mass _thyroid tenderness
Respiratory		_labored respirations _accessory muscle use _hyperinflation _hyperresonance _kyphosis _scoliosis _globally diminished breath sounds _wheezes _rales _signs of consolidation _pleural rub _decreased fremitus _dullness to percussion
Cardiovasc		_irreg rhythm _tachycardia _murmur _rub _gallop _peripheral edema _diminished pedal pulses _varicose veins
Abdomen		_hepatomegaly _splenomegaly _obesity _tenderness _diminished bowel sounds _ventral hernia
Adenopathy		_cervical _supraclavicular _other
Musculoskeletal		_muscle atrophy _muscle weakness _tremor _impaired gait _osteoarthritis
Extremities		_clubbing _cyanosis _signs of DVT _deformity
Skin		_rash or lesions
Neuro/Psych		_depressed _anxious _hypersomnolent _disoriented

COMMENTS

Neck Size



DIAGNOSES	PLANS

Follow-up in _____ Signature _____

PULMONARY ASSOCIATES OF STAMFORD, P.C.
PATIENT INFORMATION SHEET

Patient _____ Home Phone _____

Responsible Party (if minor) _____

Street Address _____

City _____ State _____ Zip _____

Sex: ___M ___F Age ___ Birthdate _____ SS# _____

Referring Physician _____

Immediate Problem _____

Chest X-Ray _____ PFT _____

Employer _____ Phone _____

Name of Primary Insurer _____

Contract # _____ Group # _____

Secondary Insurance _____

Contract # _____ Group # _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?

Name _____ Phone _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____. I assign directly to Pulmonary Associates of Stamford, P.C., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Patient Date

PULMONARY ASSOCIATES ON MEDICARE

Pulmonary Associates are participating Medicare Physicians. This means we agree to accept the Medicare approved charges as the full charge for our services. We will bill Medicare for 80% of these charges. Medicare law requires that you pay 20% coinsurance, any deductible or non-covered services. If you have additional insurance, it may pay these charges. I understand that I am responsible for the deductible, coinsurance and non-covered services as well as any legal expenses incurred, if needed, to ensure payment of my bill.

_____ _____

Signature of Patient Date