Date of Referral: _____

Connecticut Children's Patient Label
For internal use only

REFERRAL/ORDER FORM
PEDIATRIC SLEEP

FAX: 833.226.2329 or 860.545.9502
505 Farmington Avenue, Farmington CT 06032
676 Hebron Avenue, Glastonbury CT 06033
95 Reef Road, Fairfield CT 06824
282 Washington Street, Suite 1F, Hartford, CT 06106

Patient Name: (Last) _____ (First) _____
Gender: ☐ M ☐ F **DOB:** _____ **Preferred Language:** _____
Street Address: _____ **City/State/Zip:** _____
Phone: (Preferred): _____ (Secondary) _____
Parent/Guardian/DCF: _____
If DCF: (Social Worker Name) _____

This visit is: ☐ Routine ☐ Semi-urgent (within 2 weeks) ☐ **Urgent: Please call 833.733.7669.**

Insurance: _____ ID#: _____

*****In order for the sleep referral to be processed, please complete the form fully and provide the most recent/ associated office visit notes.*****

Study/Service Requested

☐ Sleep Study
☐ In-Office Sleep Medicine Consultation
☐ Insomnia/Behavioral Sleep Medicine Evaluation

Indication for Referral:

_____

_____

_____

Pertinent Medical/Surgical History, Special Needs or Accommodations:

_____

_____

_____

Referring Provider: _____ **Phone:** _____ **Fax:** _____

Primary Care Provider: (If different from referring) _____

Is the family aware of this referral? ☐ Yes ☐ No

Signature/Credentials of Provider: _____
(APRN, PA, Non-resident MD or DO)

*Questions? **Physician practices** call 1.833.733.7669. **Patients** call 860.545.9000.*

Revised March 2020