



Please FAX along with office notes and insurance card to **678.840.3777**

OFFICE TO COMPLETE

OFFICE CONTACT DETAILS			
Practice Name:	Phone:	Fax:	
PARENT/GUARDIAN AND CHILD INFORMATION			
Parent/Guardian Last Name:	Parent/Guardian First Name:	Childs First Name:	Childs DOB:
Home: <input type="checkbox"/>	Work: <input type="checkbox"/>	Mobile: <input type="checkbox"/>	
Please check the best number to reach you by phone		May we leave a message on voicemail/answering machine? YES / NO	

PARENT/GUARDIAN TO COMPLETE

Does your child snore?	Yes	No
Does your child stop breathing, gasp or struggle to breathe during sleep?	Yes	No
Does your child take longer than 30 minutes to fall asleep most nights?	Yes	No
Does your child report a "wiggly" feeling in the legs or urge to move while inactive or resting?	Yes	No
Is this feeling or urge to move made better by any sort of movement, rubbing, heat or stretching?	Yes	No
Does your child kick or seem restless during the night?	Yes	No
Does your child have difficulty staying asleep at night?	Yes	No
Does your child seem to only get sleepy after midnight or later?	Yes	No
Does your child have difficulty waking up for school or other morning activities on a regular basis?	Yes	No
Does your child seem hyperactive or sleepy when compared to other children?	Yes	No
Does your child talk, walk, scream or yell during sleep?	Yes	No
Does your child have sudden episodes of weakness with the onset of emotion?	Yes	No
Does your child require a parent to be present while falling asleep?	Yes	No

PROVIDER TO COMPLETE

Height:	Weight:	DOB:	Gender:
MEDICAL/BIRTH HISTORY:			
<input type="checkbox"/> Premature birth <input type="checkbox"/> Recurrent Otitis or Strep <input type="checkbox"/> Other <input type="checkbox"/> ICU or monitoring <input type="checkbox"/> ADHD/ADD (Please Specify)			<input type="checkbox"/> See Office Notes for Details
Allergies:	Medications:		
PRESENTING SYMPTOMS:			
<input type="checkbox"/> Snoring <input type="checkbox"/> Excessive daytime somnolence <input type="checkbox"/> Observed apnea		<input type="checkbox"/> Hyperactivity or Inattention <input type="checkbox"/> Restless Legs Syndrome (RLS) <input type="checkbox"/> Parasomnias (Please Specify)	

► MEDICAL ORDER ◀

<input type="checkbox"/> Consultation by Center Physician, Testing and Treatment as required <input type="checkbox"/> Polysomnography <u>without</u> Consult or Follow-up by Center Physician <input type="checkbox"/> Polysomnography and PAP Titration if positive for Sleep Apnea, <u>without</u> Consultation or Follow-up by Center Physician	Comments:	
Print Provider Name:	Provider Signature:	Date:

Disclosure: Consultations are performed on site by a board certified sleep physician whose practice is located within the Center. Fusion Sleep will perform medically necessary diagnostic testing in the Center based on physician orders. Patients for whom PAP therapy is prescribed have the freedom to choose their DME/homecare providers. The Center will coordinate referrals to either Fusion Sleep Therapy Services LLC or another DME/homecare provider as requested by the patient for the dispensing of therapeutic equipment. Please call Fusion Sleep, Clinical Director at 678.990.3962 for any questions or clarifications. **F080201 – Rev 10**