Children's Hospital LOS ANGELES

OVERNIGHT SLEEP STUDY PHYSICIAN ORDER SHEET

Appt. Date_____

☐ 1:1 ☐ 2:1

Criteria for 1:1

- <5 years
- Trach Capping
- New CPAP/BPAP Titration
- Uncooperative Patients

PATIENT NAME: _____ **DOB:** _____ **MR#**_____

DIAGNOSIS: 1. _____ 2. _____ 3. _____

Medications: 1. _____ 2. _____ 3. _____ 4. _____

Sleep Related Symptoms: _____ Ht: _____ Wt: _____kg

Is patient physically disabled? ☐ **NO** ☐ **YES** If *yes*, please explain: _____

Developmentally delayed? ☐ **NO** ☐**YES** **Able to Cooperate?** ☐ **NO** ☐**YES** **On supplemental 02 ?** ☐ **NO** ☐ **YES**

Is Patient on CPAP or BPAP? ☐ **NO** ☐ **YES** **NC TRACH LMP/Fi02** _____

IPAP _____ **EPAP** _____ **MODE** _____ **RATE** _____

INTERFACE_____

I TIME _____ **Ramp:** ☐ **NO** ☐ **YES** **O2 added to circuit?** ☐ **NO** ☐ **YES** **Liter Flow:** _____

TEST REQUESTED (CHECK ONE):

( ) Diagnostic Polysomnography (baseline sleep study) → NO TREATMENT/ OBSERVATION ONLY

Polysomnography with Therapy:

( ) Start study on room air, then place pt on O2 and titrate oxygen per CHLA protocol
( ) Start study with pt on oxygen (_____l/min), and titrate oxygen per CHLA protocol
( ) Assess ventilation and oxygenation during sleep with open trach

Polysomnography with Therapy Complex:

( ) Assess ventilation and oxygenation during sleep with trach capped (Requires Attending ENT approval)
( ) Split Study: Baseline sleep study 2-3 hours, then add CPAP/BPAP per CHLA protocol
( ) CPAP titrate per CHLA protocol ( ) BPAP titrate per CHLA protocol

Range goals for Sp02_____% PETC02_____mmHg

Indication for Study/Comments: _____

_____

Sleep Lab Medical Director Approval _____ **Date** _____

Referring Physician Name: _____ Phone #:_____ Fax : _____

Address:_____

Physician Signature:_____ Date:_____

Patient Label

CHILDREN'S HOSPITAL LOS ANGELES
Overnight Sleep Study
Physician Order Sheet

47-0173 (1/13)