



Nap Study Physician Order Sheet

Appt. Date _____

*Please Note: Nap Studies are most appropriate for infants and children who are taking daily naps at home.

PATIENT NAME: _____ DOB: _____ MR# _____

Ph: _____ Cell: _____ Address: _____

Ht: _____ cm Wt: _____ kg BMI _____ Age: _____

DIAGNOSIS: 1. _____ 2. _____ 3. _____

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

Sleep Related Symptoms: _____

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

Tracheostomy _____ NO _____ YES

Is patient currently on supplemental O2? _____ NO. _____ YES

Is patient developmentally delayed? _____ NO _____ YES

Is patient able to cooperate? _____ NO _____ YES

TEST REQUESTED (CHECK ONE):

Nap Study w/ _____ Sedation

Nap Study w/o Sedation

Purpose of Study:

Baseline Study

Start study on room air, then place pt on O2 and titrate oxygen to maintain SpO2> _____ %

Start study with pt on oxygen (_____ l/min), and titrate oxygen to maintain SpO2> _____ %

Study patient with open tracheostomy

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
Nap Study
Physician Order Sheet**