Children's Hospital LOS ANGELES

Appt. Date_____

Vent Check Sleep Study
Physician Order Sheet

☐ 1:1 ☐ 2:1

Criteria for 1:1
- Uncooperative Patients
- <5years
- Trach Capping
- New CPAP/BiPAP Titration

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**

Vent Type _____ **Mode** _____ **Rate** _____ **PIP** _____

PEEP: _____ **PS** _____ **I time** _____ ***LPM/FIO2:***_____

☐ Nap Study Vent Check

☐ Overnight Sleep Study Vent Check

Range goals for Sp02_____% PETC02_____mmHg

- For Sp02 < goal adjust: _____
- For Sp02> goal adjust: _____
- For PET C02 > goal adjust: _____
- For PET C02< goal adjust: _____
  - Minimum rate _____ • Maximum rate _____
    (Adjust I time with each rate change to keep 1:2 ratio)
  - Minimum PIP _____ • Maximum PIP _____
  - Minimum PEEP _____ • Maximum PEEP _____

Indication for Study/Comments:

_____

_____

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

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

Address:_____

Physician Signature: _____ Date:_____

Patient Label

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