

# THE CENTER FOR SLEEP MEDICINE

## PEDIATRIC SLEEP STUDY INFORMATION



Your child's doctor has ordered an overnight polysomnogram (sleep study) and **your child has been scheduled for this diagnostic procedure.**

**Please read all the information below** as it is critical in ensuring that the study is a success. Please **also complete the attached questionnaire and bring this with you** to your child's appointment.

### **CANCELLING A SLEEP STUDY:**

If you need to cancel your child's sleep study, **you must give the sleep center a 24-hour notice.** Please call by 5:00 p.m. on Friday to cancel a Sunday night study. **A \$250 fee will be charged for all "no shows" or cancellations without a 24-hour notification.** This fee is not covered by insurance or Medicare. To reschedule your child's study, call (708) 364-0261 Extension 1.

### **PRIOR TO THE SLEEP STUDY:**

- Complete the attached forms/questionnaires prior to your study date.
- **Avoid letting your child have caffeine for 12 hours before their scheduled time of arrival at the sleep center.**
- **Please avoid letting your child have a late afternoon nap before arriving for the sleep study.**
- Make sure your child's skin and hair are clean, and please do not use any hair products or lotions on your child the night of the study.

### **AT THE TIME OF YOUR CHILD'S SLEEP STUDY:**

**You must accompany your child to the sleep center and remain with your child until the testing procedure is completed,** at approximately 6:00 a.m. the following morning. Please arrive on time, but do not arrive any earlier than your scheduled appointment.

## WHAT TO BRING TO THE SLEEP CENTER:

- **Completed forms/questionnaires and any doctor's orders, prescriptions, or referral forms that your child's doctor has given you.** Present them to the technician upon arrival.
- **Your insurance card(s).**
- Any sleep aids that will make your child more comfortable, such as a favorite pillow, pacifiers, bottles, blankets, or special toys.
- A favorite movie (DVD), so that your child will have something to watch during the electrode hook-up procedure.
- Bedclothes are necessary. Please have your child wear something loose and comfortable, such as gym shorts and a tee-shirt, sweat pants and a tee-shirt, or pajamas.
- Any medications, both prescription and over the counter, that your child needs to take while at the sleep center. Technicians are unable to dispense any medications. A refrigerator is available for medications that need to be kept cool. **Do not have your child stop taking any of his/her medications without first consulting your child's pediatrician.**
- Any needed personal toiletries, and a change of clothes for after the study.
- You may bring snacks or juice.
- **Please do not bring any valuables with you to the sleep center.**

The rooms are supplied with pillows, blankets, towels, and washcloths.

## WHAT TO EXPECT DURING THE SLEEP STUDY:

**A Sleep Technologist will greet you and your child in the reception area at the time of your appointment.** The sleep center's private bedrooms are similar to typical hotel rooms, with private bathrooms available for showering your child after the study is completed.

**The Sleep Technologist will apply several different types of sensors to your child.** The sensors monitor brain waves, eye movements, muscle tone of the chin and legs, breathing effort of the chest and stomach, snoring volume, oxygen and carbon dioxide levels, and airflow from the nose and/or mouth.

- **Putting on the sensors does not hurt.** To obtain a recording with enough information for our Pediatric Sleep Specialist to accurately interpret the sleep study, **it is essential that most of the sensors remain in place.** To help keep the sensors on, your child's head will be wrapped with a soft, stretchy material and arm splints will be used.
- **Arm splints are applied to the arms of infants and children under seven years old following sensor placement.** The arm splints are worn to prevent your child from pulling off sensors. If the sensors come off during the study, the technician will need to come into the room to reapply them. Although some children become upset with arm splints at first, they almost always fall asleep and do very well during the night. **The arm splints help assure the quality of the recording and reduce the number of times that the technician must enter the room to reapply sensors.**

Once the sensors have been calibrated, the study will begin. During the study, it may be necessary for the Sleep Technologist to enter the bedroom to adjust or reattach sensors, assist you or your child in relation to conducting the study.

## **FREQUENTLY ASKED QUESTIONS ABOUT THE PEDIATRIC SLEEP STUDY:**

### **1. WHAT IS A POLYSOMNOGRAM (SLEEP STUDY)?**

A polysomnogram is a diagnostic study that measures the quality of sleep. A typical polysomnogram includes the following measures:

- Brain waves (electrodes placed on the scalp)
- Eye movement (electrodes placed on the face, by the eyes)
- Chin muscle tone (electrodes placed on or near the chin)
- Heart rate (electrodes placed on the chest)
- Leg movements (electrodes placed on the legs)
- Breathing (breathing sensor placed near the nose and mouth)
- Breathing effort (two small elastic belts placed around chest and abdomen)
- Oxygen level (small sensor attached to the finger)
- Audio and video recording

### **2. WHY IS IT NECESSARY TO RECORD THE ABOVE FUNCTIONS?**

During sleep, the body functions differently than while awake. Disturbed sleep, from irregular breathing or lack of sleep consolidation, can interfere with your child's daytime activities and performance in school. Poor sleep can cause a variety of behavioral, learning, and health problems.

### **3. WILL THIS PROCEDURE BE PAINFUL FOR MY CHILD?**

No. This is a painless and non-invasive (no needles) testing procedure. The electrode sensors are attached to the skin with hypoallergenic tape, similar to a Band-Aid. The electrode sensors on the scalp are put on with a paste that washes out of the hair with warm water.

### **4. HOW WILL MY CHILD SLEEP WITH ALL OF THE ELECTRODE SENSORS?**

Most children sleep reasonably well. Our goal is to obtain a sample of your child's sleep pattern. The body sensors are applied so that your child can move during sleep and change positions during the night. The sleep rooms are set up like normal, comfortable bedrooms, and our staff tries to make the environment as comfortable as possible.

### **5. WILL I NEED TO STAY WITH MY CHILD DURING THE STUDY?**

Yes, you will need to stay at the sleep center with your child during the entire testing procedure. Small children usually sit on their parent's lap during the hook-up process. In order to prevent interferences with the data acquisition during the sleep study we aim avoiding co-sleeping of parents with their child. The accompanying parent will be able to sleep in a separate bed in his child's bedroom throughout the night. The Center for Sleep Medicine has the ability to accommodate only one parent/ guardian to accompany his child.

### **6. IS THIS STUDY COVERED BY INSURANCE?**

Sleep studies are covered under most medical insurance plans, although deductibles and percentages of coverage vary. Details regarding coverage should be directed to your insurance company. We will verify insurance benefits and coverage prior to your sleep study. Feel free to call The Center for Sleep Medicine at (708) 364-0261 and speak with the Account Coordinator, who is available to answer any remaining questions or concerns you may have.

**THE CENTER FOR SLEEP MEDICINE**  
**PEDIATRIC SLEEP QUESTIONNAIRE**

Please fill out the following questionnaire with information pertaining to your child.

**IDENTIFYING INFORMATION**

Patient First and Last Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Weight: \_\_\_\_\_ Lbs. Height: \_\_\_\_\_ Ft./in  
 Name of person completing questionnaire: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_

**PRESENTING PROBLEM**

Please briefly describe your child's main sleep-related complaint: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**USUAL SLEEP HABITS**

Please describe your child's *typical* sleep schedule:

1. On *weekdays*, my child goes to bed at: \_\_\_\_\_ (AM or PM?); wakes at: \_\_\_\_\_ (AM or PM?).
  2. On *weekends*, my child goes to bed at: \_\_\_\_\_ (AM or PM?); wakes at: \_\_\_\_\_ (AM or PM?).
  3. How long does it usually take your child to fall asleep? \_\_\_\_\_ (Indicate minutes or hours)
  - 4a. How many times does your child wake up during the night? \_\_\_\_\_
  - 4b. How long does it usually take your child to return to sleep? \_\_\_\_\_ (Indicate minutes or hours)
  - 4c. My child is relatively  EASY or  DIFFICULT (*check one*) to wake up in the morning.
- |  |                          |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  | Never                    | Little                   | Weekly                   | 2-3 times/wk             | Daily                    |
| 5. How often does your child <i>usually</i> nap? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
6. Please describe any sleep comforts your child uses (e.g. blankets, plush toys or animals): \_\_\_\_\_  
 \_\_\_\_\_

**SLEEP SYMPTOM DESCRIPTION**

Please help us understand the nature of your child's sleep difficulties. Check any statement that applies:

1.  My child snores
2.  My child's bed covers are very messed up in the morning
3.  My child tosses and turns at night and is a restless sleeper
4.  My child kicks, jerks, or has limb movements (arms or legs) during sleep
5.  My child has stopped breathing while asleep
6.  My child refuses to go to bed, sleep in their own bed or go to sleep without assistance
7.  My child wakes mid-sleep and cannot go back to sleep without assistance
8.  My child has frequent nightmares
9.  My child has frequent night terrors
10.  My child sleep walks... How many times per week on average? \_\_\_\_\_
11.  My child wets his/her bed... How many times per week on average? \_\_\_\_\_
12.  My child is excessively sleepy during the daytime

**A MEASURE OF YOUR CHILD'S DAYTIME SLEEPINESS**

How likely is your child to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your child's usual way of life in recent times. Even if your child has not done some of these things recently, try to predict how each situation would have affected your child. Use the following scale to choose the most appropriate number for each situation:

Chance of Dozing:	0 = No chance	1 = Slight chance	2 = Moderate chance	3 = High chance
-------------------	---------------	-------------------	---------------------	-----------------

<i>Situation:</i>	<i>Chance of Dozing (0-3)</i>
1. Sitting and reading	<input type="text"/>
2. Watching TV	<input type="text"/>
3. Sitting inactive in a public place (e.g., movie theater)	<input type="text"/>
4. As a passenger in a car for an hour without a break	<input type="text"/>
5. Lying down to rest in the afternoon when circumstances permit	<input type="text"/>
6. Sitting and talking to someone	<input type="text"/>
7. Sitting quietly after lunch	<input type="text"/>
8. In a car, while stopped for a few minutes in traffic	<input type="text"/>

**YOUR CHILD'S MEDICAL CONDITIONS**

1. Please check all items that apply to your child:
- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Easily distracted   | <input type="checkbox"/> Hyperactive           | <input type="checkbox"/> Anxiety or nervousness                 |
| <input type="checkbox"/> Overweight          | <input type="checkbox"/> Underweight           | <input type="checkbox"/> Bedwetting (if over 4 years of age)    |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Sinus Problems        | <input type="checkbox"/> Dizziness or passing out               |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Seizures              | <input type="checkbox"/> High blood pressure                    |
| <input type="checkbox"/> Chronic pain        | <input type="checkbox"/> Depression            | <input type="checkbox"/> Tonsillectomy/Adenoidectomy            |
| <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Irregular heart beat  | <input type="checkbox"/> Deviated septum/crooked or broken nose |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Learning disabilities |   |

2. Were the pregnancy and/or delivery with your child complicated?  Yes  No  
 If yes, describe: \_\_\_\_\_

3. Was your child born on time?  Yes  No If "No," how premature was your child? \_\_\_\_\_

4. Please describe any other medical conditions or current physical complaints: \_\_\_\_\_

5. Please list all medications that your child takes, doses and time of administration: \_\_\_\_\_

6. Has your child undergone any surgeries? If yes, please explain below:  Yes  No

7. Does your child have any allergies? If yes, please describe these below:  Yes  No

**OTHER INFORMATION**

1. Please describe any additional information you feel may affect your child's sleep:

---

---

---

2. Please describe any special needs your child may have, in particular any that may affect treatment or care with us:

---

---

---

**FAMILY HISTORY**

1. Does anyone else in your family have sleep problems?  Yes  No

If yes, describe their relationship to your child (e.g. mother, father, sister) and their condition:

---

---