

THE CENTER FOR SLEEP MEDICINE

Child Diagnostic Sleep Study (6-17 years old)

Your child has been scheduled for a 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.

We try to schedule appointments as close as possible to a child's normal sleep/wake pattern. If your child goes to bed early in the evening, or late at night, let us know so we can accommodate you. If you need to change the scheduled appointment time, please notify the center immediately.

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 or stimulants for 12 hours before their scheduled time of arrival at the sleep center.**
- 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.

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 their 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 sleep center's private bedrooms are similar to typical hotel rooms, with private bathrooms available for showering after the study is completed. The rooms are supplied with pillows, blankets, towels, and washcloths.

INFORMATION ABOUT THE SLEEP STUDY

1. WHAT IS A POLYSOMNOGRAM (SLEEP STUDY)?

A polysomnogram is a 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 THE SENSORS HURT 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. Some parents of small children choose to sleep in the bed with their child during the study, while other parents decide to sleep in a separate room nearby.

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 describe your main complaint by checking one or more of the items below and providing a brief explanation of how your child may experience these difficulties:

- 1. My child has trouble falling asleep
- My child is sleepy all day
- My child has unwanted behaviors while asleep
- Other

2. Explain: _____

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)

	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

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"/> Deviated septum/crooked or broken nose |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Tonsillectomy/Adenoidectomy |

2. Please describe any other medical conditions or current physical complaints: _____

3. Please list all medications that your child takes.

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

5. 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:

Pre Evaluation Pediatric Sleep LogFor the week prior to your child's appointment, please complete the following sleep log **each day** as accurately as you can.

	Sample	Night 1	Night 2	Night 3	Night 4	Night 5	Night 6	Night 7
Indicate date and day of the week:	10/5 Monday							
What time did your child go into bed?	8:00 pm							
What time did your child get up?	6:00 am							
Approximately how many hours did your child sleep last night?	8½ hrs							
How long did it take your child to fall asleep?	30 min							
How many times did your child awaken?	1							
Estimate the total time your child was awake during one or more awakenings?	1 hour							
List the time and duration of any naps your child took during the day?	1:30 pm. (1 hour)							
List any over-the-counter or prescription sleep medication your child took last night:	None							
Rate the quality of your child's sleep (1-5): (1= Very Poor, 2 = Poor; 3 = Fair; 4 = Good; 5 = Very Good)	2							
Other information about your child's night: (e.g. Nightmares, Bedwetting, Bedtime refusal, etc.):								