Preparation guidelines for your Child's Sleep Study

- Maintain your child's regular night sleeping and nap schedule for several days before the study.
- On the day of the study, do not let your child have any food or drink with caffeine such as chocolate, coffee, tea or soft drinks.
- Please have your child eat a normal evening meal. You may want to bring light snack for you and your child.
- On the day of the study, bathe your child and shampoo their hair. Do not use conditioner, hair spray, gel, body lotions or oils. These can disturb the sensor-to-skin contact needed to obtain data.
- Bring things from home that will make your child more comfortable in the Lab. Suggestions are a special blanket, stuffed animal, toothbrush, books, VCR tapes and pillow.
- **One parent or caregiver will need to stay overnight. Only the parents or guardians are allowed to stay with the child. Please bring proof of legal guardianship to the sleep study.** Children 13 and under must be attended by a parent/guardian at all times. Adults intending on staying the night of the study need to bring photo identification. Adults without proper identification will be requested to leave for security reasons. Please make care arrangements for siblings and other family members.
- Please bring the child's insurance information, i.e. insurance card and/or letter of insurance authorization.
- Continue your child's normal medications, unless told by the physician to stop them.
- If your child becomes ill or has a change in his/her condition please notify us as soon a possible.
- Bring your child's medications to the hospital the night of the test**. This is very important.** You will be responsible for giving the medications to your child, as the technician is not permitted to do so. If your child wears diapers, please bring those supplies too.
- If your child has special medical or physical needs, please let us know so that we can make arrangements to provide for your child's needs.
- Please bring a pair of pajamas (the 2 piece footless type) and a change of clothes.
- Complete attached questionnaire.
- We offer tours of the Sleep Center to help make children more comfortable. If you would like to schedule a tour, call the Sleep Center at 816-932-3207

These guidelines are to help us provide you and your Physician with an accurate Sleep Study. If you have any question about these guidelines, please call the Sleep Disorders Center at 816-932-3207.

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Parent or Guardian's Signature   Date

SAINT LUKE'S HOSPITAL of KANSAS CITY- SLEEP DISORDERS CENTER
PEDIATRIC CLINICAL POLYSOMNOGRAM QUESTIONNAIRE

Name ______________________________________ Age_______ Height _________
Address _____________________________________ Sex_______ Weight_________
____ Race______

Phone Number ( ) ______________________ Work Number ( ) ___________________

Referring Physician_________________ Family Physician __________________

Phone Number: ( ) _______________ Phone Number: ( )__________________

How did you hear about the Sleep Disorders Center at Saint Luke's Hospital? _______________
____

Questionnaire completed by: ____________________ Relation to patient: _____________

1. Please describe your child's sleep problem as best as you can:________________________
____
____
____

2. When did the problem begin? (Month and or year)___________________________________

3. Has he/she ever had a sleep study? ( ) Yes ( ) No
If yes, where and what were the results? ______________________________________
____

4. Current medical problem(s)? ____
____
____

Please list all current medications:

TYPE OF MEDICATIONS	DOSE	FREQUENCY

Allergies (medication, skin or sinus related):_____________________________________
____

Brief Medical history including surgeries:____
____
____
____
____

8. My child's ideal amount of sleep is _______________ hours per night.

During the week my child:
Goes to bed at ___________ (time)
Wakes up at _______________ (time)
Sleeps a total of ____________ (hours)
Naps ______(hours) ________(times per day)

During the weekend my child:
Goes to bed at ____________time
Wakes up at ________________time
Sleeps a total of _______________ hours
Naps ______(hours) ________(times per day)

After a nap does you child appear:
( ) Refreshed, ( ) Fairly Rested, ( ) Somewhat tired, ( ) Very Drowsy

Typically, it takes him/her ___________ minutes to fall asleep and he/she gets up ____________ times per night. If he/she gets up, what is the reason? __________________________________
____

My child's bed or sleeping surface is ( ) Crib ( ) Standard Mattress ( ) other _____________

9. How difficult is it to awaken your child in the morning?
Not at all Somewhat Moderately Extremely

10. Does your child have his/her own bed and bedroom? ( ) Yes ( ) No If no, please explain ____

10. Can he/she fall asleep by him/herself? ( ) Yes ( ) No If no, what happens? ____________
____

11. Does your child snore?
NIGHTLY WEEKLY RARELY NEVER
Snoring started at age__________ Snores while in all positions ( ) Yes ( ) No
Snoring is described as ( ) Mild ( ) Moderate ( ) Loud

12. I hear pauses in his/her breathing at night?
NIGHTLY WEEKLY RARELY NEVER

13. Does your child have trouble with nose or nasal breathing? ( ) Yes ( ) No If yes, please Explain: ____
____

14. Does your child wake up with a headache?
NIGHTLY WEEKLY RARELY NEVER N/A

15. Wets the bed: (older than the age of 5)
NIGHTLY WEEKLY RARELY NEVER N/A

16. Grinds his/her teeth:
NIGHTLY WEEKLY RARELY NEVER N/A

17. Toss and turn an extreme amount:
NIGHTLY WEEKLY RARELY NEVER N/A

18. Has nightmares:
NIGHTLY WEEKLY RARELY NEVER N/A

19. Sleepwalks:
NIGHTLY WEEKLY RARELY NEVER N/A

20. Sleep talks:
NIGHTLY WEEKLY RARELY NEVER N/A

21. Screams in his/her sleep:
NIGHTLY WEEKLY RARELY NEVER N/A

22. Sees frightening visual images before falling asleep or upon waking:
NIGHTLY WEEKLY RARELY NEVER N/A

23. Reports being unable to move when falling asleep or upon waking:
NIGHTLY WEEKLY RARELY NEVER N/A

24. Kicks legs in sleep:
NIGHTLY WEEKLY RARELY NEVER N/A

25. Complains of an uncomfortable feeling in his/her legs; creepy-crawly feeling:
NIGHTLY WEEKLY RARELY NEVER N/A

26. Appears weak or loses muscle control when experiencing strong emotion (e.g. laughing, crying, having a tantrum)
NIGHTLY WEEKLY RARELY NEVER N/A

27. Does your child consume food/beverages containing caffeine? (e.g., chocolate, soft drinks, tea and/or chocolate milk)? ( ) Yes ( ) No
If yes, how many cups/servings per day and what item are consumed? __________________
____

29. Is there any history in your family of difficulties with sleep, sleep apnea, excessive daytime sleepiness?____
____

***If your child is not in school, please skip to the bottom of the next page.**

30. What level of schooling is your child enrolled in? ____________________

31. Has your child been diagnosed or suspected to have, ADD or ADHD?
( ) Yes ( ) No If yes, please explain____
____

32. Has your child ever repeated a grade?
( ) Yes ( ) No If yes, please explain____
____

33. Is your child enrolled in any special education classes?
( ) Yes ( ) No If yes, please explain____
____

34. Do you think sleepiness had affected your child performance and/or behavior at school?
( ) Yes ( ) No If yes, please explain____
____

35. Has your child's teacher ever expressed concerns about his/her level of alertness and/or daytime sleepiness at school?
( ) Yes ( ) No If yes, please explain____
____

36. Has your child's teacher ever expressed concerns about his/her behavior at school?
( ) Yes ( ) No If yes, please explain____
____

How would you rate his/her grades this year:

EXCELLENT GOOD AVERAGE POOR FAILING

How would you rate his/her grades last year::

EXCELLENT GOOD AVERAGE POOR FAILING N/A

I hereby authorize the Sleep Disorders Center at Saint Luke's Hospital to release the results of my procedure to any physician participating in my care, or to the home health care agency designated by my physician to perform any follow-up care.

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PATIENT'S OR GUARDIAN'S SIGNATURE DATE

What happens during the sleep study?

Your child will come to a private bedroom with a full size bed. Special video cameras and microphones record all sounds and movements your child makes during sleep. A sleep technician will place many sensors on your child to help collect data. You will see lots of wires running to the sensors.

The technician will apply:

- A cleaning gel to the skin and scalp prior to electrode placement
- Electrodes on the face and scalp to measure brain waves and eye movements using a special "ouch less" tape and special adhesives
- Sensors placed around the nose and mouth to measure breathing
- Patches on the chest and legs to measure the heartbeat and leg movements
- Soft belts around the chest and abdomen that measure efforts to breathe
- A sensor on a finger or toe that measures oxygen in the blood
- Our goal is to obtain 7 to 8 hours of recorded data. Once this goal has been reached, the sensors will then be gently removed.