CHILDREN'S MEMORIAL HOSPITAL
SLEEP MEDICINE CENTER
DIVISION OF PULMONARY AND CRITICAL CARE MEDICINE
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Children's Sleep Medicine Center
Accredited
American Academy of Sleep Medicine

MEMBER CENTER

SLEEP MEDICINE REFERRAL / CONSULTATION REQUEST

PATIENT: _____ PHYSICIAN: _____
ADDRESS: _____ PHYSICIAN'S PHONE: _____
PHONE: _____ PHYSICIAN'S FAX: _____

SPECIFIC REQUEST

PLEASE CHECK ONE:

[ ] **SLEEP STUDY/POLYSOMNOGRAM**
Report will be sent to the referring physician. Referring physician will do follow-up with patient/parent.

[ ] **SLEEP STUDY/POLYSOMNOGRAM WITH FOLLOW-UP**
Report will be sent to the referring physician. Sleep Medicine Center Staff will follow-up with patient/parent.

[ ] **COMPREHENSIVE EVALUATION INCLUDING, INITIAL CONSULTATION, POLYSOMNOGRAM IF NEEDED, AND FOLLOW-UP**

[ ] OTHER _____

REASON FOR REFERRAL:

MEDICAL HISTORY AND PERTINENT PHYSICAL EXAM FINDINGS:

ALLERGIES?

MEDICATIONS?

WHAT TIME IS THE CHILD'S USUAL BEDTIME? _____			DOES THE CHILD HAVE NIGHTMARES?	YES	NO
HOW LONG DOES IT TAKE HIM/HER TO FALL ASLEEP? _____			DOES HE/SHE SCREAM IN SLEEP?	YES	NO
DOES THE CHILD WAKE AT NIGHT?	YES	NO	IS THERE TEETH GRINDING DURING SLEEP?	YES	NO
IS THE CHILD SLEEPY DURING THE DAY?	YES	NO	DOES THE CHILD SLEEPWALK?	YES	NO
DOES THE CHILD HABITUALLY NAP?	YES	NO	DOES THE CHILD WET THE BED?	YES	NO
DOES THE CHILD BANG HEAD IN SLEEP?	YES	NO	DOES THE CHILD SNORE?	YES	NO
IS THE CHILD A RESTLESS SLEEPER?	YES	NO	DOES THE CHILD MOUTH BREATHE?	YES	NO
DOES THE CHILD HAVE LEG PAINS?	YES	NO	DOES THE CHILD KICK DURING SLEEP?	YES	NO

Pediatric Sleep Questionnaire: Sleep-Disordered Breathing Subscale

070129

Child's Name: _____ **Study ID #:** _____

Person completing form: _____ **Date:** ___/___/___

Please answer these questions regarding the behavior of your child during sleep and wakefulness. The questions apply to how your child acts in general during the past month, not necessarily during the past few days since these may not have been typical if your child has not been well. You should circle the correct response or *print* your answers neatly in the space provided. A "Y" means "yes," "N" means "no," and "DK" means "don't know."

1. WHILE SLEEPING, DOES YOUR CHILD:				
Snore more than half the time?	Y	N	DK	A2
Always snore?	Y	N	DK	A3
Snore loudly?	Y	N	DK	A4
Have "heavy" or loud breathing?	Y	N	DK	A5
Have trouble breathing, or struggle to breathe?	Y	N	DK	A6
2. HAVE YOU EVER SEEN YOUR CHILD STOP BREATHING DURING THE NIGHT?	Y	N	DK	A7
3. DOES YOUR CHILD:				
Tend to breathe through the mouth during the day?	Y	N	DK	A24
Have a dry mouth on waking up in the morning?	Y	N	DK	A25
Occasionally wet the bed?	Y	N	DK	A32
4. DOES YOUR CHILD:				
Wake up feeling unrefreshed in the morning?	Y	N	DK	B1
Have a problem with sleepiness during the day?	Y	N	DK	B2
5. HAS A TEACHER OR OTHER SUPERVISOR COMMENTED THAT YOUR CHILD APPEARS SLEEPY DURING THE DAY?	Y	N	DK	B4
6. IS IT HARD TO WAKE YOUR CHILD UP IN THE MORNING?	Y	N	DK	B6
7. DOES YOUR CHILD WAKE UP WITH HEADACHES IN THE MORNING?	Y	N	DK	B7
8. DID YOUR CHILD STOP GROWING AT A NORMAL RATE AT ANY TIME SINCE BIRTH?	Y	N	DK	B9
9. IS YOUR CHILD OVERWEIGHT?	Y	N	DK	B22
10. THIS CHILD **OFTEN**:				
Does not seem to listen when spoken to directly.	Y	N	DK	C3
Has difficulty organizing tasks and activities.	Y	N	DK	C5
Is easily distracted by extraneous stimuli.	Y	N	DK	C8
Fidgets with hands or feet or squirms in seat.	Y	N	DK	C10
Is "on the go" or often acts as if "driven by a motor".	Y	N	DK	C14
Interrupts or intrudes on others (eg., butts into conversations or games).	Y	N	DK	C18

Thank you!