Scheduled Appointment Information

Date and Time: ____________AT ____________ PM

Location: 1800 S. Renaissance Blvd. Edmond, OK 73013

Please arrive at **Summit Medical Center. Enter through the main entrance and take the elevator to the 2nd floor.** If there is not a receptionist available, please have a seat in the waiting room and your technician will come out to greet you at the time of your study.

- **Due to the increased volume of patients if you arrive more than 15 minutes after your scheduled time, the appointment may be given to someone else. If you are running late the night of your study, please contact a technician at 405-844-3319 to hold your spot.**

IMPORTANT**: All minors must have a parent or guardian stay with them throughout the entire test.**

* **Reminder:** If possible, no naps or caffeine the day of the study. Please make sure to bring everything your child will need for the entire evening.

Things to bring with you:

1. The enclosed questionnaire – (please complete prior to arrival)
2. Something comfortable to sleep in and any other necessities for your child throughout the night.
3. A list of medications that the child is currently taking- (please have them written down prior to arrival)
4. The child's insurance card and a form of identification, such as a picture I.D.

Things to remember:

1. Questions regarding your medications should be referred to your physician.
2. Please administer all of your child's medications as you normally do, unless otherwise directed by your physician.
3. Please bathe and wash your child's hair prior to arrival. Avoid hair products and excessive lotions.
4. We have pillows; however, please feel free to bring your own to add to your comfort.
5. Bring an overnight bag with the items you would normally use for an overnight stay.
6. Smoking materials, tobacco, and firearms are prohibited in our facility.
7. Please complete all smoking prior to coming up to the sleep disorders center.
8. You should contact our office, and speak directly to our staff, if you have any of the following on the day you are scheduled for your sleep study: Flu, diarrhea, fever, severe nasal congestion, or migraine headache. If you feel you need to reschedule your sleep study, please contact our staff at **405-949-0060**.

Insurance & Financial Information:

If you have any questions regarding your financial responsibility please feel free to call Summit Medical at **405-359-2477**. You will be responsible for the actual contracted amount if the claim is not paid in full. We urge you to contact your insurance provider member services to verify the information above.

Any scheduling questions should be directed to Sleep Solutions, M-F 8-5, at 405-949-0060 or 866-748-4350. Our patient care coordinator will be happy to answer any questions you may have.

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PEDIATRIC SLEEP QUESTIONNAIRE (School-Aged)

Patient Name: ____________________ Date: __________

Record #: ______________________ Age: ___ Sex: (circle one) M F

Date of Birth: __________ Height: _____ Weight: ______ BMI: _____

Referring Physician/Provider: ________________________

Primary Care Physician/Provider: ______________________

General Questions:

1. What is the child's main sleep problem? ______________________________
2. How long has this problem been present? ______________________________
3. Has the child had a previous sleep study? Yes___ No ___ When: _____________

   Where:____
4. Has your child been treated with a CPAP device: Yes___ No ___ Type of Machine ______

   How often is it used? ____

Questions for School Aged Children:

1. What is the child's normal bedtime during school days? __________________

   What is the usual bedtime on week-ends or vacation? __________________
2. What time does your child get out of bed on school days? ________________

   What time on week-ends of vacation? __________________(am or pm)
3. After sleeping, is the child: Rested _____ Tired _____ Sleepy _____
4. Does the child take naps? Yes __ No __ Time of day? ____ Times per week? ______
5. Does the child sleep alone? Yes ___ No ___
6. How many times per night does the child awaken? _______
7. How long does it take the child to fall asleep? _______

Patient Name: ____________________
Date: ____________________

If delayed, why?____

8. Does the child take medicines or drink caffeine that causes wakefulness? (cokes and sodas, energy drinks): Yes ___ No ___ What are they? ____________________

9. Does your child snore? Yes ___ No ___ Loudly? Yes ___ No ___

10. Have you noticed the child to stop breathing while asleep? Yes ___ No ___

    How often? ____

11. Does your child: Have nightmares? Yes ___ No ___ How Often: __________

    Sleepwalk: Yes ___ No ___ How Often? ____________ Times/Week: ______

    Sleep Talk: Yes ___ No ___ How Often? ____________ Times/Week: ______

    Wet the bed: Yes ___ No ___ How Often? ____________ Times/Week: ______

12. Are there any other sleep problems noted in the child? Yes ___ No ___

    Describe: ____

13. What is your child's average grade in school? (circle one) A B C D F

14. Has your child been diagnosed with attention deficit or hyperactivity (ADHD)?

    Yes ___ No ___ Medication for this: ______________

15. Does sleepiness and fatigue affect your child's classroom performance? Yes ___ No ___

16. Does your child fall asleep in class? Yes ___ No ___

17. Has your child had problems with fighting and aggression? Yes ___ No ___

18. Have his/her teachers reported learning problems, behavior problems or sleepiness to to the parents? Yes ___ No ___ If so, which one? ____________________

Patient Name: ____________________

Date: ____________________

Past Medical History:

1. Does the child have any significant current or past medical problems? Yes ___ No ___
   Describe: ____

2. Has your child had:

   a. ADHD? Yes ___ No ___

   b. Tonsillectomy and/or adenoidectomy? Yes ___ No ___

   c. Seizures? Yes ___ No ___

   d. Lung Disease? Yes ___ No ___ Asthma? Yes ___ No ___ Use O_2? Yes ___ No ___

   e. Heart disease: Yes ___ No ___ Type of heart problem: ____________________

   f. Diabetes? Yes ___ No ___

   g. Genetic disorder? Yes ___ No ___ Type: ____________________

   h. Facial or jaw development problems? Yes ___ No ___

      Describe: ____

   i. Mental retardation or development problems? Yes ___ No ___

      Describe: ____

Surgical History: (List all previous surgeries and the date done.)

______________________________ Date: ______________

______________________________ Date: ______________

______________________________ Date: ______________

______________________________ Date: ______________

Patient Name: ______________________
Date: ______________________

____ Date: ________________

Medications: (List all current medications and dosage and when they were last taken.)

________________________________ Dosage: _______________ Date: ________________

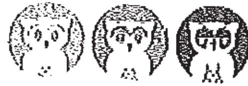
________________________________ Dosage: _______________ Date: ________________

________________________________ Dosage: _______________ Date: ________________

________________________________ Dosage: _______________ Date: ________________

________________________________ Dosage: _______________ Date: ________________

________________________________ Dosage: _______________ Date: ________________



pediatric sleep center
OF OKLAHOMA

Modified Pediatric Epworth Sleepiness Scale (Ages 6-16)

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.

Use the following scale to choose the most appropriate number for each situation. Circle your answers and see where you stand.

Situation	Chance of Dozing or Sleeping			
	None	Slight	Moderate	High
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
Being a passenger in a motor vehicle for an hour or more	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch	0	1	2	3
Playing video games	0	1	2	3

Total score (add the scores up)
This is your Epworth score ____________

Patient Name: ______________________________ Date: ____________________