UCLA Health System
Sleep Disorders Center
10833 Le Conte Avenue, B Level
Los Angeles, CA 90095
1-310-26SLEEP (7-5337)

MRN:
Patient Name:

(Patient Label)

Welcome to the UCLA Sleep Disorders Center

Our Sleep Center Website is: http://sleepcenter.ucla.edu

Your sleep study appointment is scheduled for **8:30 PM**. Please feel free to arrive up to **15** minutes early for your appointment. Patients arriving after **8:45 PM** may need to be rescheduled. If you need to cancel your appointment, kindly call 48 hours in advance.

Please bring your insurance card(s) and/or insurance authorization number(s) if applicable.

Insurance: authorizations must be processed prior to scheduling a sleep study appointment through your referring Doctors office. Even though you will be spending the night in the sleep center, the sleep study is considered an outpatient procedure.

For questions about insurance coverages, copayments, or billing, please contact your insurance representative to determine your personal coverage. Your insurance carrier will be billed for technical (the test) and professional (the interpretation) services; however, services not covered or remaining balances will be your financial responsibility.

Enclosed you will find the following:

- Directions to the Sleep Disorders Center
- Parking information
- How to prepare and what to bring to your sleep study
- What to expect during your sleep study
- A sleep questionnaire

Please complete every page of the attached packet and bring it with you to your appointment.

Our department has earned an outstanding reputation in subspecialty care of sleep disorders due to a high level of clinical expertise, academic achievement and innovative research. Our most important mission is to provide each patient with the best sleep medicine health care available by combining our extensive experience with the latest advances in the treatment of sleep disorders. Our faculty and staff work together as a team to bring each patient the highest quality of care in a warm, friendly and professional environment.

We look forward to caring for you.

Sleep Center Staff

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Directions to the Clinical and Translational Research Center and UCLA Sleep Disorders Center

Directions from 405 Freeway

- Take Wilshire Blvd East exit
- Turn left at Westwood Blvd
- Turn right at Le Conte Ave (at the Chick-fil-a)
- Turn left on Tiverton Ave (Ralph's will be on the right)

Directions from Downtown

- Take the 10 Freeway West towards Santa Monica
- Exit on to the 405-N
- Take the Wilshire Blvd East exit
- Turn Left at Westwood Blvd
- Turn right at Le Conte Ave (at the Chick-fil-a)
- Turn left on Tiverton Ave (Ralph's will be on the right)

- **Stay STRAIGHT to enter the TUNNEL towards the Patient and Visitor Parking (Lot 18 & 27)**

- **Turn RIGHT at the stop sign to enter the Patient and Visitor Parking Lot 27 for CTRC/Sleep Center Parking.**

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- **Once parked, go to the nearest pay station.**
  - ❖ **Hourly rate: (Day time studies)**
    - One hour $3
    - Two hours $6
    - Three hours $9
  - ❖ **Daily rate:$12 (Overnight Studies)**

- **Follow instructions on key pad.**
- **Pay using EXACT cash amount or with a credit card.**
- Additionally, pay station **only** accepts **$1 & $5 and DOES NOT give change** in the form of cash or credit.
- **Once finished, Display Permit on DASH**

- **Proceed to the MAIN ENTRANCE of CTRC/Sleep Disorder Center.**

- **Once inside both doors, ring the doorbell on the left hand side.**
  - ❖ **Note: If you arrive before 8:00pm, please have a seat in our waiting room; Our Sleep Technologists will begin checking you in at 8:15pm.**

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UCLA Sleep Disorders Center
Facts about your Child's Sleep Recording

Our staff will be doing everything possible to make your Child's night's stay in the Sleep Center as comfortable as possible. However, the application of electrodes to his/her head and face area as well as wires to measure breathing and other delicate sensors may disturb his/her sleep somewhat. This is normal and your child's cooperation and patience is appreciated will make our job easier and your stay more pleasant. Some other important facts:

- Please bring pajamas or a two-piece outfit for your child to wear, as well as any medications your child may need.
- Please shower and wash your hair BEFORE coming to the Lab. Don't use hair spray or oils in your child's hair. This will ensure better adhesion of electrodes.
- Small gold-cupped wires (electrodes) will be filled with cream and taped to or near your child's chin, ears, head, chest, legs and near you're his/her eyes. This takes about one hour. All electrodes and sensors are placed using hypoallergenic tape. Please let us know if you have a known skin allergy.
- All electrodes and sensors are placed using hypoallergenic tape. Please let us know if your child's have a known skin allergy.
- In some cases, after the study has begun, a technologist may need to re-enter your room to reposition sensors or to begin CPAP treatment.
- The technologists are awake all night and you may call them if you need them.
- You will be on a video monitor throughout the night. Recordings are used by Sleep Specialist Physicians only. Recordings are not available for transfer or copy.
- The lab technologist who removes the electrodes in the morning may not be the same technologist who applied the electrodes the night before.
- You are expected to arrive at your scheduled time as other patients are also scheduled on the same night. Late arrivals may forfeit their appointments.
- Except for going to the bathroom, your child must stay in bed throughout the night, resting quietly if awake.
- For patients scheduled for additional recordings the following day, breakfast and lunch facilities are available, but are at cost to the patient. Please bring enough money for these meals. Please bring a lunch-sized cooler for your food items. We do have a refrigerator for patient food. We do have a microwave; please ask for assistance.
- The technologists are highly trained and knowledgeable; however, they may not give you any information regarding your sleep study results or medical condition(s).
- Results will be available in 10 working days, and may be discussed in detail with your physician.
- Sleep study reports sent to the referring physician(s) only. If you wish to obtain a copy of your report, please contact the Medical Records Department.
- Sleep recordings are highly specialized medical procedures that require time and care in performing and analyzing. Please try to cooperate as best you are able.

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WELCOME TO UCLA'S SLEEP DISORDERS CENTER

In preparation for your child's appointment, would you kindly take a moment to answer these routine questions and give the completed form to your child's doctor at the time of his/her appointment. It will help him/her to become oriented quickly to your child's problem so that more time will be available to focus on the main issues and to answer your questions.

Don't worry too much about providing great detail to the questions. The questions are meant simply as an overview. The doctor will probably ask you to elaborate on several of the issues, and you should feel encouraged to tell him/her anything else which is not included here, but which you think might be important to your child's case.

CHILD'S NAME: ____ **DOB:** ______________
AGE: __________ **Years,** ___________ **months** **Height:**_______ **Weight** ______

1. Please briefly describe the problem for which you are seeking a pediatric neurology consultation/ pediatric sleep consultation:

____
____
____
____

2. PREGNANCY & DELIVERY

A. How many pregnancies did you have before this child? ____________________________
B. Did you have any illnesses or complications during this pregnancy? If so, what were they?
____
____

C. Was baby born full term? _______ If not, how many weeks gestation? ________
D. Was delivery vaginal? _________
If Cesarean section, what were the indications? __________________________________
E. How long was the labor? _______ Birth weight? ______________
F. When the baby was born, did he/she cry right away? _________________
Describe any problems the baby had in the first few days after birth.
____
____
____

3. GENERAL HEALTH

Aside from the usual colds and flu's, has your child had any special health problems, major illnesses, surgery, etc.? __________ If so, please describe:
____
____

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4. DEVELOPMENT (please refer to your baby book if possible)

How old was the baby when he/she first did the following?

smiled responsively __________
rolled over __________
sat unaided __________
crawled __________
pulled to stand __________
walked __________
ran __________
walked upstairs __________
walked down stairs __________
rode a tricycle __________
rode a bicycle __________
said first words __________
put 2 or 3 words together __________
began to help in dressing __________
dressed self independently (except shoelaces) __________
was able to tie shoelaces by self __________

Handedness (right, left, ambidextrous) __________________ became apparent at age: _________

5. SCHOOLING

A. Is your child attending school? __________ B. What grade is your child in now? ______
C. What school? ________________________ D. How are his/her grades? ____________
E. Are there any behavior or attention problems at school? _______
If yes, when did this start? ____

6. FAMILY

A. Please list the names and ages of brothers and sisters in chronological order

Name	Age	Brother/ sister	Specific health condition (please specify)

B. On either side of the family, has anyone ever experienced any of the following conditions:
Please check all that apply and explain below

sudden infant death
epilepsy
seizures
paralysis
retardation
cerebral palsy
learning disabilities
hyperactivity
tumor
sleep problems
other
neurologic condition (please specify): ______________________________

If any condition was checked above, please explain: ______________________________
____
____

C. Describe any other medical conditions which run in the family:
____
____

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D. Have there been any divorces, deaths, or other relevant family problems which might affect the child? ______If so, please explain: ____

____

7. REVIEW OF SYSTEMS

Please check if your child has had a problem with any of the following:

_____ headaches	_____ poor or double vision
_____ impaired vision	_____ speech/ language problems
_____ weakness	_____ incoordination/ clumsiness
_____ lethargy/ sleepiness	_____ hyperactivity
_____ vomiting	_____ seizures or convulsions
_____ a heart condition	_____ a problem with stomach/ intestines
_____ dizziness	_____ a problem with kidneys or bladder

_____ allergies (to what?) ____

_____ other (explain) ____

8. MEDICATIONS

Please list all the medications, with their dosages, which your child is currently taking:

	Medication	Dose	Frequency
1.	____________________	________	______________
2.	____________________	________	______________
3.	____________________	________	______________
4.	____________________	________	______________
5.	____________________	________	______________
6.	____________________	________	______________
7.	____________________	________	______________
8.	____________________	________	______________

9. OTHER

If you have any further notes that you may not want to forget to tell the doctor, please write it down here:

____
____
____
____

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UCLA SLEEP DISORDERS CENTER

PEDIATRIC SLEEP QUESTIONNAIRE

What are the specific sleep problems that have led to the referral?

1. ____
2. ____
3. ____

Please describe the impact on parents, family, and school:

____ child sleeps alone _____ child sleeps with sibling
____ child co-sleeps with parent(s) or caregiver

Usual bed time: _____________ Wake time: ________ Nap time: _______

Please describe the child's bedtime routine: (parent participation, need of transitional object, etc.)

____
____
____
____

Question	Yes	No
a. Is bedtime routine adhered to consistently?	_____ Yes	_____ No
b. Do you experience bedtime struggles with your child?	_____ Yes	_____ No
c. Does the child settle quickly with caregiver intervention?	_____ Yes	_____ No
d. Does child express fear going to sleep?	_____ Yes	_____ No
e. Does child experience head banging, racking?	_____ Yes	_____ No
f. Does child stay awake > 1 hour before falling asleep?	_____ Yes	_____ No
g. Does child awaken crying, fearful, or confused?	_____ Yes	_____ No

Frequency: ________ First half of the night ______ Last half of night_______

Does child experience any of the following? Please check all that apply and note their frequency:

	Frequency		
___sleep walking	________________________	snoring/ choking	____________
___sleep talking	________________________	mouth breathing	____________
___nocturnal seizures	________________________	pauses in breathing	____________
___bedwetting	________________________	asthma attacks at night	____________
___grinding teeth	________________________		
___nocturnal pain	________________________	restless sleeper	____________
___sleep paralysis	________________________	light sleeper	____________
___nightmares	________________________	heavy sleeper	____________
___difficulty awakening in am	____________________	depressed mood	____________
___awakening too early	________________________	behavior problems	____________
___disturb other's sleep	________________________	learning problems	____________
___sleepy in school	________________________	peer interactions	
___irritable in daytime	________________________	problematic	____________
___day time spells	________________________		
___impulsive	_________________________	short attention span	____________

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FAMILY HISTORY

Circle the appropriate alternative word.

Mother: Living or deceased? Age _____ Specific health conditions: ___________________________________
Father: Living or deceased? Age _____ Specific health conditions: ___________________________________

Brothers and/or sisters: List from oldest to youngest. Circle the appropriate alternative word.

1. brother or sister? living or deceased? Age _____ Specific health conditions ____________________________________
2. brother or sister? living or deceased? Age _____ Specific health conditions ____________________________________
3. brother or sister? living or deceased? Age _____ Specific health conditions ____________________________________
4. brother or sister? living or deceased? Age _____ Specific health conditions ____________________________________
5. brother or sister? living or deceased? Age _____ Specific health conditions ____________________________________
6. brother or sister? living or deceased? Age _____ Specific health conditions ____________________________________
7. brother or sister? living or deceased? Age _____ Specific health conditions ____________________________________
8. brother or sister? living or deceased? Age _____ Specific health conditions ____________________________________

Children: List from oldest to youngest. Circle the appropriate word.

1. daughter or son? living or deceased? Age _____ Specific health conditions _____________________________________
2. daughter or son? living or deceased? Age _____ Specific health conditions _____________________________________
3. daughter or son? living or deceased? Age _____ Specific health conditions _____________________________________
4. daughter or son? living or deceased? Age _____ Specific health conditions _____________________________________

Have any of the following conditions occurred in other members of your family? If so, in whom?

heart disease ___________________________________ stroke _____________________________________
high blood pressure ___________________________________ faints _____________________________________
high cholesterol ___________________________________ diabetes _____________________________________
memory loss ___________________________________ cancer _____________________________________
epilepsy or seizures ___________________________________ M..S. _____________________________________
depression/ psychosis ___________________________________ polio _____________________________________
muscle weakness ___________________________________ limping _____________________________________
thyroid disease ___________________________________ sleep problems _____________________________
Other (please specify______________________) ___________________________________

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OUTPATIENT NOTES

Medical Records

Person completing these forms: ____________________________________ Relationship to patient: _______________________________

The above information -- Past medical history, family history, social history and review of systems-- may be obtained as a questionnaire completed by the patient, relatives or ancillary staff provided that it is signed and dated by the treating physician. (Reference may later be made to this information by a signed and dated statement by the treating physician, designating location of the information, date obtained and any subsequent changes.)

Signature of physician: ____

Date: _____________________________