Welcome to the UCLA Sleep Disorders Center
Our Sleep Center Website is: http://sleepcenter.ucla.edu

Sleep Study for: ____________________________

Appointment Date: Sun Mon Tue Wed Thu Fri Sat ____________ at 8:00PM - 6:00AM (Next Day)

Check in at: FRONT DESK
Attn: You MUST call us to confirm your appointment within 48 hours of your apt. date.

All patients requiring PAP titrations or tracheostomy suctioning do require COVID-19 negative testing 1-2 days prior to their overnight study.

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 re-scheduled.

If you need to cancel your appointment, kindly call 48 hours in advance.

Insurance: authorizations must be processed prior to scheduling a sleep study appointment through your referring doctor’s 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.

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

Enclosed you will find the following:

- Directions to the Sleep Disorders Center
- Parking information and fees
- How to prepare and what to bring to your sleep study
- What to expect during the 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
UCLA Sleep Disorders Center
Facts about your Child’s Sleep Recording

Our staff will be doing everything possible to make your child’s night 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.

☐ 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.

☐ Please shower and wash 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.

☐ Except for going to the bathroom, your child must stay in bed throughout the night, resting quietly if awake.

☐ Small cupped wires (electrodes) will be filled with cream and taped to or near your child’s chin, ears, head, chest, legs and near his/her eyes. This takes about one hour.

☐ For patients scheduled for additional recordings the following day, breakfast and lunch are not provided. Please bring a lunch-sized cooler for your food items. We do not have a refrigerator for patient food.

☐ All electrodes and sensors are placed using hypoallergenic tape. Please let us know if your child has a known skin allergy.

☐ The technologists are awake all night and you may call them if you need them.

☐ The technologists are highly trained and knowledgeable; however, they may not give you any information regarding the sleep study results or medical condition(s).

☐ In some cases, after the study has begun, a technologist may need to re-enter the room to reposition sensors or to begin CPAP treatment.

☐ Results will be available in approximately two weeks, and may be discussed in detail with your physician.

☐ Video monitoring is done throughout the night. Recordings are used by Sleep Specialist Physicians only. Recordings are not available for transfer or copy.

☐ Sleep study reports are sent to the referring physician(s) only. If you wish to obtain a copy of your report, please contact the Medical Records Department.

☐ The lab technologist who removes the electrodes in the morning may not be the same technologist who applied the electrodes the night before.

☐ 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.
In preparation for your child’s appointment, kindly take a moment to answer these routine questions and bring with you at the time of his/her appointment.

Don’t worry too much about providing great detail to the questions. The questions are meant simply as an overview.

1. Please briefly describe your child’s sleep problems:

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

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:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
4. **DEVELOPMENT**

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 downstairs
- 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

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Brother/sister</th>
<th>Specific health condition (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:
____________________________________________________________________________
____________________________________________________________________________
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
- _____ impaired vision
- _____ weakness
- _____ lethargy/ sleepiness
- _____ vomiting
- _____ a heart condition
- _____ dizziness
- _____ allergies (to what?)
- _____ other (explain)

8. **MEDICATIONS**

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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. **OTHER**

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

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
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.)
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

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:

| Sleepwalking | SleepTalking | NocturnalSeizures | Bedwetting | GrindingTeeth | NocturnalPain | SleepParalysis | Nightmares | DifficultyAwakeningInAm | AwakeninTooEarly | DisturbOther’sSleep | SleepyInSchool | IrritableInDaytime | DaytimeSpells | Impulsive | Snoring/Choking | MouthBreathing | PausesInBreathing | AsthmaAttacksAtNight | RestlessSleeper | LightSleeper | HeavySleeper | DepressedMood | BehaviorProblems | LearningProblems | PeerInteractions | Problematic | ShortAttentionSpan |
|--------------|--------------|------------------|------------|---------------|---------------|---------------|-------------|----------------------|-----------------|----------------------|--------------|------------------|--------------|------------|----------------|-----------------|------------------|------------------|----------------|---------------------|----------------|------------------|----------------|-----------------|----------------|----------------|----------------|-----------------|----------------|------------------|
|              |              |                  |            |               |               |               |             |                      |                 |                      |              |                  |              |            |                |                 |                  |                  |                 |                     |                |                  |                |                 |                |                  |                 |                     |                |                  |                |                 |                |                  |                 |                     |                |                  |                |                 |                |
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.)
Directions from the 405 Freeway

• Take the Wilshire Blvd East Exit (WESTWOOD)
• Turn Left on Westwood Blvd
• Turn Right on Le Conte Ave
• Turn Left at the Tiverton Ave Light
• Enter Straight into Geffen Hall Tunnel
• Turn Right to Visitor Parking Lot #27

Once parked, go to the pay station.
Remember your license plate number.
Follow instructions on keypad, entering your license plate number.
Pay using EXACT cash amount or with credit card or download the ParkMobile app on your phone.  https://parkmobile.io/

Pay station only accepts $1 & $5 bills only. It DOES NOT give change in the form of cash or credit.

You have arrived at
Clinical and Translational Research Center (CTRC)
UCLA Sleep Disorders Center
Proceed to the glass ENTRANCE doors in Lot #27

Parking Fees
All Day $14
All Night $8
2 Day Pass $20
3 Hours $9
2 Hours $6
1 Hour $3