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 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.

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
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.
• Once parked, go to the nearest pay station.
  ❖ **Hourly rate:** [Daytime 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.
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.

- 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 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.

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

- 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.

- 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 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 your sleep study results or medical condition(s).

- 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.

- Results will be available in 10 working days, and may be discussed in detail with your physician.

- 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.

- 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.

- 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.
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:
      _______________________________________________________________________
      _______________________________________________________________________
      _______________________________________________________________________
4. **DEVELOPMENT (please refer to your baby book if possible)**
How old was the baby when he/she first did the following?

- Smiled responsively: _______
- Walked down stairs: _______
- Rolled over: _______
- Rode a tricycle: _______
- Sat unaided: _______
- Rode a bicycle: _______
- Crawled: _______
- Said first words: _______
- Pulled to stand: _______
- Put 2 or 3 words together: _______
- Walked: _______
- Began to help in dressing: _______
- Ran: _______
- Dressed self independently (except shoelaces): _______
- Walked upstairs: _______
- 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? _______
   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>
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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
- _____ 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:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
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<tbody>
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</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:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
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.)
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

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:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>sleep walking</th>
<th>sleep talking</th>
<th>nocturnal seizures</th>
<th>bedwetting</th>
<th>grinding teeth</th>
<th>nocturnal pain</th>
<th>sleep paralysis</th>
<th>nightmares</th>
<th>difficulty awakening in am</th>
<th>awakening too early</th>
<th>disturb other’s sleep</th>
<th>sleepy in school</th>
<th>irritable in daytime</th>
<th>day time spells</th>
<th>impulsive</th>
<th>short attention span</th>
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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
- high blood pressure
- high cholesterol
- memory loss
- epilepsy or seizures
- depression/psychosis
- muscle weakness
- thyroid disease
- Other (please specify____________________)

- stroke
- faints
- diabetes
- cancer
- M.S.
- polio
- limping
- sleep problems

Other (please specify____________________)
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: ______________________________