Welcome to the UCLA Sleep Disorders Center

Welcome to the UCLA Sleep Disorders Center located at 10833 Le Conte Ave, B Level (previously the Emergency Room in CHS). Los Angeles CA 90095. To serve you best, we would like to tell you about our services:

Enclosed you will find a map with directions to the Sleep Disorders Center as well as more information regarding your sleep testing. In this packet, you will also find materials we are requesting you to complete and bring with you to your appointment. To ensure that the physicians at the UCLA Sleep Disorders Center make an accurate diagnosis and assessment, we need to have this information. This will help us become oriented with any medical or other conditions that may be impacting your sleep.

You are scheduled to arrive at the Sleep Disorders Center at 8:30 pm. You may arrive up to 15 minutes prior to your appointment. If you are arriving late, be sure to call us. **Any patients arriving past 9pm may need to be rescheduled.** You must call at least 48 hours in advance if you need to cancel your appointment. Please bring your completed questionnaire, insurance card(s), insurance authorization number(s) if applicable, your overnight bag and any medications you will need during your time here. The sleep center will be unable to dispense medications like a pharmacy; therefore you must make sure to bring all of your medications. Please refer to the Facts Sheet included in this packet for more information about your sleep study.

Please complete every page of the attached 14-page packet and bring it with you to your appointment.

**Insurance.** Please contact your insurance representative to determine your coverage. Your carrier will be billed for you appointments; however, any charges not covered or remaining balances will be your financial responsibility. **Authorizations must be processed before we may give you an appointment. Inform your insurance carrier that you will be undergoing an outpatient sleep study. Although you will be spending the night in our sleep laboratory, this is an outpatient study.**

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 seeing you here.

Sleep Center Staff
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 (just after Ralph’s) and follow the parking directions below

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 (just after Ralph’s) and follow the parking directions below

Parking Directions

- Enter the CHS Parking Structure on the left.
- Upon entering parking structure take a right to Patient and Visitor parking *(You will go up one level and then down one level to Patient and Visitor Parking)*
- Please follow the Orange Patient and Visitor signs to designated Sleep Center Parking on the A level of the CHS parking structure. Make sure you place the Parking Pass face up on your dashboard.
- Once parked there will be a Yellow Line on the ground. Please follow this line into the building. This line will take you to the elevators and you will proceed down to the B level.
- When you exit the elevator you will continue to follow the Yellow Line to the Sleep Center.
- If you get lost, call 310-267-1038 or 310-267-0444

Please See Attached Map for Designated Parking Spaces
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 your child’s 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.
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:

<table>
<thead>
<tr>
<th>Action</th>
<th>Age</th>
<th>Action</th>
<th>Age</th>
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<tbody>
<tr>
<td>Smiled responsively</td>
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<td>Walked down stairs</td>
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<tr>
<td>Rolled over</td>
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<td>Rode a tricycle</td>
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<tr>
<td>Sat unaided</td>
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<td>Rode a bicycle</td>
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<tr>
<td>Crawled</td>
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<td>Said first words</td>
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<tr>
<td>Pulled to stand</td>
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<td>Put 2 or 3 words together</td>
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<tr>
<td>Walked</td>
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<td>Began to help in dressing</td>
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<td>Ran</td>
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<td>Dressed self independently</td>
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<td>Walked upstairs</td>
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<td>Was able to tie shoelaces by self</td>
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</table>

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>
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</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
- _____ poor or double vision
- _____ speech/ language problems
- _____ incoordination/ clumsiness
- _____ weakness
- _____ hyperactivity
- _____ lethargy/ sleepiness
- _____ incoordinaton/ clumsiness
- _____ vomiting
- _____ seizures or convulsions
- _____ dizziness
- _____ a heart condition
- _____ a problem with stomach/ intestines
- _____ 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:

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<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
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<tbody>
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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>Snoring/choking</th>
<th>Mouth Breathing</th>
<th>Pauses in Breathing</th>
<th>Asthma Attacks at Night</th>
<th>Restless Sleeper</th>
<th>Light Sleeper</th>
<th>Heavy Sleeper</th>
<th>Depressed Mood</th>
<th>Behavior Problems</th>
<th>Learning Problems</th>
<th>Peer Interactions</th>
<th>Problematic</th>
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<td>Sleep Walking</td>
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<td>Bedwetting</td>
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<td>Difficulty Awakening in AM</td>
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<td>Awakening Too Early</td>
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<td>Disturb Other’s Sleep</td>
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<td>Irritable in Daytime</td>
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UCLA Form #11528  Rev. (5.2013)
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) ____________________________
**REVIEW OF SYSTEMS**

Please place a check mark in front of any of the following items which the patient is experiencing at present.

(Disregard the numbered bold Medicare headings in quotes on the left, which are for administrative purposes only):

1. "constitutional":
   - _____ fever
   - _____ weight loss
   - _____ fatigue

2. "eyes problems":
   - _____ blurred vision
   - _____ double vision
   - _____ loss of vision
   - _____ eye pain
   - _____ eye redness
   - _____ eye dryness

3. "ear/nose/throat":
   - _____ trouble hearing
   - _____ ringing in ear(s)
   - _____ dizziness (vertigo)
   - _____ loss of balance
   - _____ ear pain
   - _____ ear discharge
   - _____ double vision
   - _____ ear redness
   - _____ loss of vision
   - _____ eye dryness

4. "cardiovascular":
   - _____ chest pain
   - _____ irregular heart beat
   - _____ heart burn
   - _____ fast heart beat
   - _____ limb pain on walking
   - _____ fainting

5. "respiratory":
   - _____ trouble breathing
   - _____ chronic cough
   - _____ coughing blood

6. "gastrointestinal":
   - _____ indigestion
   - _____ heart burn
   - _____ abdominal pain
   - _____ nausea
   - _____ vomiting
   - _____ regurgitation
   - _____ diarrhea
   - _____ constipation
   - _____ bloody stools
   - _____ diarrhea
   - _____ vomiting
   - _____ constipation
   - _____ bloody stools

7. "genitourinary":
   - _____ incontinence
   - _____ pain on urination
   - _____ blood in urine

8. "musculoskeletal":
   - _____ muscle pain
   - _____ muscle cramp
   - _____ muscle twitch
   - _____ loss of muscle bulk
   - _____ neck pain
   - _____ back pain
   - _____ joint pain
   - _____ joint stiffness
   - _____ joint swelling

9. "skin & breast":
   - _____ numbness
   - _____ tingling
   - _____ discoloration
   - _____ hair loss
   - _____ nail changes
   - _____ sweating changes

10. "neurologic":
    - _____ headache
    - _____ face pain
    - _____ face numbness
    - _____ weakness
    - _____ tremors
    - _____ clumsiness
    - _____ blackouts
    - _____ trouble with memory
    - _____ trouble concentrating

11. "psychiatric":
    - _____ hallucinations
    - _____ feeling depressed
    - _____ trouble sleeping
    - _____ suicidal thoughts
    - _____ inappropriate crying
    - _____ inappropriate laughing

12. "hematologic/lymphatic":
    - _____ abnormal bleeding
    - _____ nose bleeds
    - _____ lumps or swellings

13. "allergic/immunologic":
    - _____ skin rash
    - _____ joint pain
    - _____ dry eyes &/or dry mouth

14. "endocrine":
    - _____ excessive thirst
    - _____ heat or cold intolerance
    - _____ excessive urination

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**OUTPATIENT NOTES**

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.)