MedStar Georgetown University Hospital

Georgetown University Hospital
Sleep Disorders Center

3800 Reservoir Road, NW
Washington DC, 20007
5th Floor Main Building #5411

To the Parent(s) of:

Your child has been scheduled for a sleep study on:

Appointment Date and Time: @ 8:30pm
Discharge Date and Time: @ 6:00 am

You will be staying in the “Sleep Disorders Center” overnight; we have enclosed additional information for your reference. If a questionnaire is enclosed, please fill it out and bring it with you to your appointment.

The sleep study or polysomnogram is non-invasive and painless. Electrical sensors are attached by wire to monitoring devices that are used to document brain wave activity eye movements, chin muscle, leg movements, oxygen saturation and respiratory activity. These painless sensors are applied temporarily with gauzes and tape. The equipment may be minimally uncomfortable, but does not prevent sleep or interfere with a meaningful sleep study. It is preferred that at least six hours of testing be obtained in order to provide a comprehensive sleep evaluation for the Doctor. Once the study has started, you have the right to discontinue the test for any reason; however, please be aware that a shorter test may not be as reliable or as useful for the interpreting physician. The full charge for the study will be submitted for payment. Sleep Center patients cannot stay in the lab and sleep without properly being monitored. **Please note that patients under 18 years old must be accompanied by a parent or guardian.** For patient safety and to obtain accurate test results, no children other than the patient undergoing the testing procedure can be allowed to stay overnight.

We will verify your insurance program and benefits; however, some insurance providers require a Physician’s referral prior to scheduling, which must be obtained by the patient. If a referral is required, we will request it at the time of scheduling. If we do not receive the necessary Pre-Authorization and/or Referral, your appointment may be rescheduled. Please note that a sleep study is not considered an inpatient hospital stay, but rather is an overnight outpatient diagnostic test. In the event that your insurance company asks about procedure codes or “CPT” codes, please give them whichever of the following is applicable:

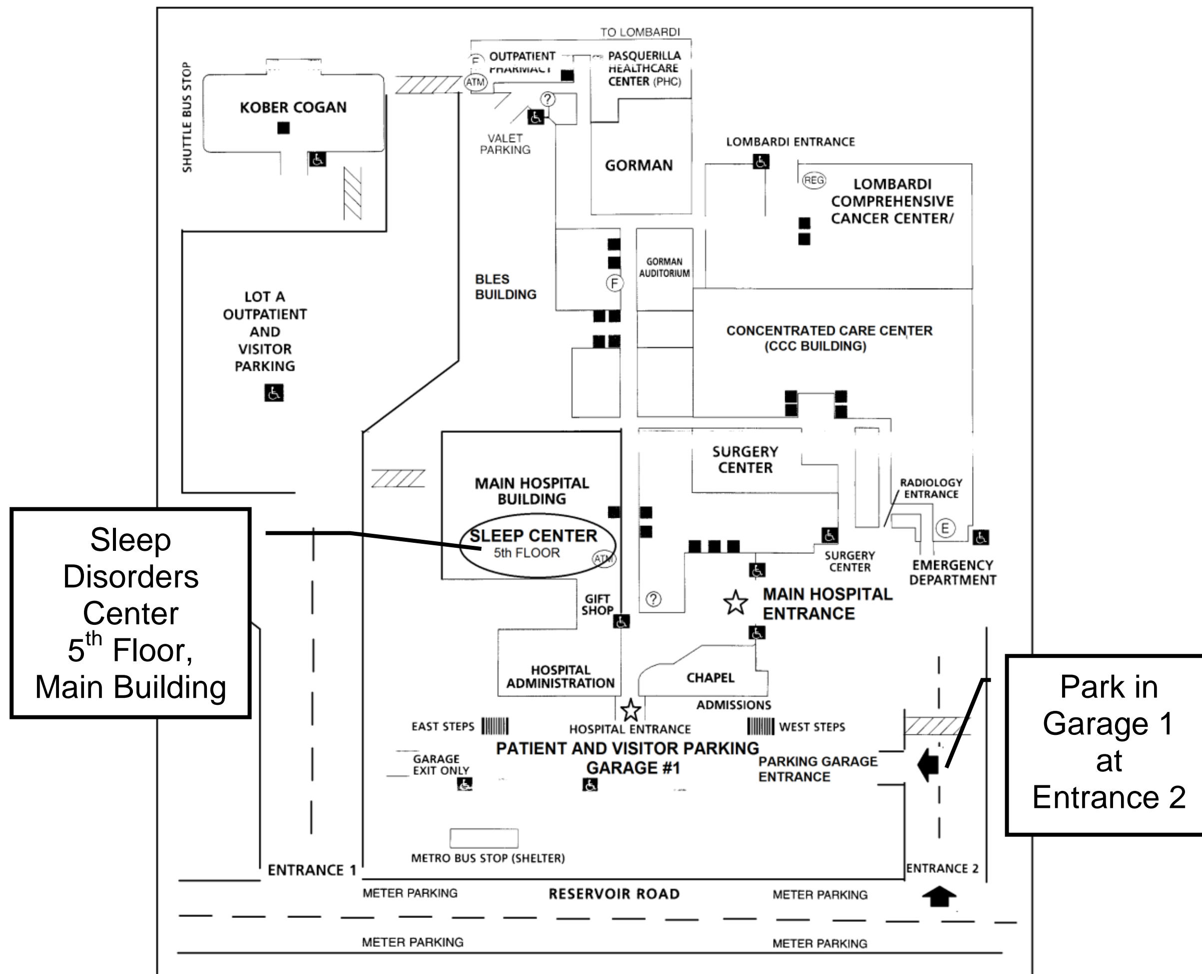
Diagnostic Sleep Study:	CPT 95810
Sleep Study with Nasal CPAP Treatment:	CPT 95811
Split Night PSG with CPAP:	CPT 95811
Multiple Sleep Latency Test (MSLT):	CPT 95805

We are an outpatient department, and patients will be assigned a room according to the type of study that their physician has ordered. Rooms with bathrooms cannot be requested in advance. In most rooms, bathrooms are located inside the room, but in some cases they are adjacent or across from the sleep rooms. Although the restroom may not be in the bedroom, every patient room has access to a restroom with a shower.

If a change occurs in your schedule we would appreciate 24 hours notice of appointment cancelations or rescheduling. Please also note that *if your child is sick on the date of your appointment, the appointment should likely be rescheduled* in order to ensure the most accurate test results.

The contact number for appointment confirmation, cancelations and rescheduling is 202-444-3610. The office hours are Monday through Friday, 8:00 am to 4:30 pm. To inform us of an unexpected after-hours cancellation of an appointment, page (202) 405-5438.

<u>When you arrive at the Hospital:</u> You should enter the Hospital campus by Entrance 2 (look for the Emergency Room sign) and park in Garage 1. Please bring your parking ticket into the Hospital for validation. Validated parking costs $6 - $12. Handicapped Parking is available in Garage 1. The Sleep Center is located on the 5th floor of the Main Hospital Building. Enter the hospital through either of the Main Building entrances, which remain unlocked until 9:00PM.



Departure: Testing is usually complete at 6:00 a.m. at which time all monitoring devices are removed and you may leave the Sleep Disorders Center. If you need to leave prior to 6:00 a.m. please inform your Technologist. Shower facilities are available.

Results: The results of your test will be sent to your referring physician. Contact the office of your physician to schedule an appointment to discuss results of the study. All results are confidential and will be shared only with you through your physician. Technologists cannot convey any tests results after testing as the study must be reviewed by a physician. Final results generally are forwarded to the ordering physician in 7-10 business days.

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Please keep the following in mind when preparing for your sleep study:

- Shower and shampoo your hair on the day of your study. Hair should be clean and free of any hair spray, mousse, gels, oils, etc. If you have a hairpiece that is glued to the scalp, we may be unable to conduct the test (single braided hair and most hair extensions do not pose a problem).
- Gentlemen should plan on shaving prior to the study. You are not required to remove a mustache or beard.
- NO naps during the day on the day of your study.
- NO caffeinated beverages after 12:00 noon on the day of your study, or during testing.
- NO alcoholic beverages on the day of your study. Please note that Georgetown University Hospital is a tobacco-free campus.
- NO facial make-up, face creams or skin products on your face.
- If you have acrylic/artificial nails on your fingers, you must remove at least one for the study. If you have nail polish or acrylic nails on when you arrive for your study, the Technologist will have to remove the nail polish and/or the acrylic nail from one finger. This is necessary for accurate oxygen saturation readings during the study.
- Eat dinner prior to arriving for your appointment. You may bring a snack if you will be hungry prior to the beginning of study.

Remember to Bring:

- Medication you normally take, including non-prescription medications. The Sleep Disorders Center cannot provide any medications. Take your prescription medications unless instructed otherwise by your physician. If you regularly use sleeping medications, bring them with you.
- Comfortable sleepwear - preferably pajamas or shorts and a top. Sleepwear is not optional – it is required. Please, no satin or satin-like material.
- Personal items such as toothbrush, toothpaste, brush and comb.
- Bring a pillow, if you prefer your own. White noise machines are acceptable.
- If you are currently a CPAP user, bring your mask.
- Reading material or something to keep you busy before bedtime
- Your insurance card and picture identification.

Please note: If you have any special nursing needs or disabilities and need special assistance, please bring your care-giver with you to your appointment. Also, please keep in mind that Georgetown University Hospital is a smoke free campus.

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Pediatric Sleep History Questionnaire

Child's Name______________________ Date of Birth:___________ Ht:_______ Wt:_______

1. What is your child's normal bedtime on a weekday?________________________________ am / pm
2. What is your child's normal wake time on a weekday?______________________________ am / pm
3. What is your child's normal bedtime on a weekend or holiday?_________________________ am / pm
4. What is your child's normal wake time on a weekend or holiday?_______________________ am / pm

5. Does your child take a nap during the day? If so, how long is the nap? __________________________

6. On average, how may hours of sleep does your child get during a 24 hour period? __________________

7. Is your child ever difficult to awaken in the morning or difficult to waken from a nap?
   - ❑ Yes
   - ❑ No

8. Does your child snore at night?
   - ❑ Never
   - ❑ Rarely (less than once a month)
   - ❑ Occasionally (1-4 times a month)
   - ❑ Frequently (more than once a week)
   - ❑ Most nights

9. Please describe the loudness of the snoring.
   - ❑ No snoring
   - ❑ Faint(can't hear unless near the child
   - ❑ Light (can hear it, not bothersome)
   - ❑ Moderate(easy to hear, not too loud
   - ❑ Heavy(loud, bothersome, can hear outside of child's room)

10. If your child snores, what percentage of the night does this happen?
    - ❑ Doesn't snore (0%)
    - ❑ Occasionally (less than 50%)
    - ❑ Intermittently (about 50%)
    - ❑ Frequently (more than 50% of the night)
    - ❑ Continuously (at least 90% of the night)

11. Have you ever witnessed your child having difficulty or struggling to breathe during sleep?
    - ❑ Never
    - ❑ Rarely (less than once a month)
    - ❑ Occasionally (1-4 times a month)
    - ❑ Frequently
    - ❑ Most nights

12. Does your child's chest "cave-in" or "see-saw" during sleep?
    - ❑ Never
    - ❑ Rarely (less than once a month)
    - ❑ Occasionally (1-4 times a month)
    - ❑ Frequently
    - ❑ Most nights

13. Have you ever witnessed pauses in your child's breathing during sleep?
    - ❑ Never
    - ❑ Rarely (less than once a month)
    - ❑ Occasionally (1-4 times a month)
    - ❑ Frequently
    - ❑ Most nights

14. Do you ever shake your child or attempt to waken them to make them resume breathing?
    - ❑ Never
    - ❑ Rarely (less than once a month)
    - ❑ Occasionally (1-4 times a month)

- ❑ Frequently
- ❑ Most nights

15. How long has your child had breathing problems?
    - ❑ No Problems
    - ❑ Less than 3 months
    - ❑ Less than 6 months
    - ❑ More than 1 year
    - ❑ Since he/she was a baby

16. Does your child sleep in any unusual positions (for ex: neck hyper-extended or with his/her bottom up in the air)?
    - ❑ Never
    - ❑ Rarely (less than once a month)
    - ❑ Occasionally (1-4 times a month)
    - ❑ Frequently (more than once a week)
    - ❑ Most nights

17. Does your child have excessive body movements or body position changes throughout the night?
    - ❑ Never
    - ❑ Rarely (less than once a month)
    - ❑ Occasionally (1-4 times a month)
    - ❑ Frequently (more than once a week)
    - ❑ Most nights

18. Does your child complain of funny, creepy-crawly feelings in his/her legs before falling asleep or want his/her legs rubbed?
    - ❑ Never
    - ❑ Rarely (less than once a month)
    - ❑ Occasionally (1-4 times a month)
    - ❑ Frequently (more than once a week)
    - ❑ Most nights

19. Does your child have nightmares?
    - ❑ Never
    - ❑ Rarely (less than once a month)
    - ❑ Occasionally (1-4 times a month)
    - ❑ Frequently (more than once a week)
    - ❑ Most nights

20. Does your child walk / talk during sleep.
    - ❑ Never
    - ❑ Rarely (less than once a month)
    - ❑ Occasionally (1-4 times a month)
    - ❑ Frequently (more than once a week)
    - ❑ Most nights

21. If your child is over 5 years, does he/she wet the bed?
    - ❑ Never
    - ❑ Rarely (less than once a month)
    - ❑ Occasionally (1-4 times a month)
    - ❑ Frequently (more than once a week)
    - ❑ Most nights

22 Does he/she sweat heavily during sleep?
- ❑ Never
- ❑ Rarely (less than once a month)
- ❑ Occasionally (1-4 times a month)
- ❑ Frequently (more than once a week)
- ❑ Most nights

23Does your child fall asleep in school or nap after school?
- ❑ Yes
- ❑ No

24. Does your child complain of feeling tired all day?
- ❑ Never
- ❑ Rarely (less than once a month)
- ❑ Occasionally (1-4 times a month)
- ❑ Frequently (more than once a week)
- ❑ Most days

25. Does your child complain of morning headaches?
- ❑ Never
- ❑ Rarely (less than once a month)
- ❑ Occasionally (1-4 times a month)
- ❑ Frequently (more than once a week)
- ❑ Most days

26. Is your child a daytime mouth-breather?
- ❑ Yes
- ❑ No

27.How would you describe your child's appetite presently?
- ❑ Poor
- ❑ Typical/Average
- ❑ Excessive

28. Has anyone in the family ever been diagnosed or treated for sleep apnea?
- ❑ Yes
- ❑ No

29.Has anyone in the family ever died of SIDS (Sudden Infant Death Syndrome)?
- ❑ Yes
- ❑ No

30.Has your child ever had surgery on his/her neck or throat / tonsils or adenoids taken out?
- ❑ Yes
- ❑ No

If yes, please
describe____
____

Please any medical problems/medical diagnoses your child has.

____
____
____
____
____

31.Does your child take any medications (pills, shots, vitamins, herbs, etc.)?
If yes, list below the names and amounts of all medications he/she is taking and state how often and why he/she takes each one.

Medication	**Dose**	**How often**	**Reason**

32. On average how much caffeine (if any) does your child consume per week? ______________________ servings.

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33. How likely is your child to doze off or fall asleep in the following situations? How often do you feel tired? This refers to your usual way of life in recent times. Even if your child has not done some of these things recently, try to evaluate how they would affect you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of dozing**
Sitting and reading	
Watching TV	
Sitting, inactive, in a public place (e.g., school or movie)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch	
In a car, while stopped for a few minutes in traffic	

34. Year of last complete physical examination: ____

Examining physician's name: ____

Physician's address: ____

Office telephone number: ______________________ MD's specialty: ____________________________

35.Was anything found wrong in your last physical examination? ☐Yes ☐No
If yes, describe: ____
____

Remarks: If there are any other aspects of your child's sleep problem which you feel are important, please describe them in the space below. Also, list any medications that were not listed above.

____
____
____
____
____
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____
____