

# Sleep Disorder's Center

1200 7<sup>th</sup> Avenue North  
St. Petersburg, FL 33705  
O: 727.820.7424  
F: 727.820.7431  
Scheduling: 727.820.7760



## *CHILD/ADOLESCENT*

### *Night Baseline Sleep Study*

#### **Patient/Guardian:**

Your child/adolescent has been scheduled for an overnight sleep study (polysomnogram) at the St. Anthony's Hospital Sleep Disorder's Center.

You should arrive at the **St. Anthony's Sleep Disorders Center at 8:00 p.m. (enter through the ground floor parking garage)**. You will be finished with the test and ready to leave by no later than 6:30 a.m. the following morning. Before the test, you will be shown a video about the treatment of sleep apnea and your questions will be answered. You will be hooked up to some wires before bedtime (11:00 p.m.). You will be able to get out of bed during the night if necessary.

A map and instructions to follow before your sleep study are enclosed. If you are scheduled for a nap study the next day please read the attached information sheet.

**If you cannot keep this appointment, you must contact our scheduling office 48 hours prior to your study date.** If your normal sleeping hours **are not** during the night due to your work schedule, please contact our office as soon as possible. The scheduling office is open Mon. – Fri., 8:00 a.m. – 4:00 p.m., phone (727) 820-7424.

**\*THE LEGAL GUARDIAN MUST STAY ALL NIGHT WITH THE MINOR\***  
**We will provide the bedding**

#### ***Overnight Sleep Study***

##### **Night & Date:**

**Time:**                      **8:00 P.M.**

**Place:**                      **The Sleep Disorders Center  
St. Anthony's Hospital  
1200 7<sup>th</sup> Avenue North  
St. Petersburg, FL 33705-1300**

- **Press the white button at the parking garage entrance and tell the operator "who you are and that you are here for a Sleep Study".**

## Preparing for a sleep study

### **INSTRUCTIONS TO FOLLOW THE NIGHT/DAY BEFORE YOUR SLEEP STUDY:**

1. **Keep your usual bedtime** schedule the night/day before your study.
2. **Avoid “sleeping in” or napping** on the day of your study.
3. **Avoid any activities that may interfere with your sleep** on the night/day of your study.
4. **Avoid any beverages or food items containing caffeine** on the day/night of your study.
5. **It is best to avoid alcohol for 1 week** prior to your study.
6. **Take all medications as prescribed by your physician unless told otherwise by your physician.** \*\*Bring prescribed medications, over-the-counter products, head-ache medicines, diabetes supplies and breathing treatment supplies that you need to take or use at night with you in its original labeled bottle/package, we are not a nursing department and do not have medications on hand. **\*\*If you are taking any sleeping medications, we recommend that you do not drive following the test.**
7. **You should shower and wash your hair** prior to coming to the Sleep Center, **do not** use any oils, mousse, tonics or hairspray on your hair.

### What To Bring:

1. **You must bring your Insurance Card, Photo ID and your Sleep Study Prescription** (if you have one).
2. **Bring loose comfortable clothing to sleep** in (i.e. pajamas, a baggy sweat suit, or shorts and a T-shirt). Long nightgowns are not suggested they may interfere with testing. Technologist reserve the right to not perform the sleep study if you **DO NOT** bring sleeping clothes with you. Sleeping in the nude is **NOT** permitted.
3. **Bring any toiletries** you may want before/after the study. There are restrooms and a shower in the Sleep Disorders Center.
4. **Please eat your evening meal/breakfast before arriving.** Bring any special diet snack foods that you may require before bed. We will have light snacks and ice water, juice, hot decaf coffee or tea available. If you are scheduled for daytime testing the following day, breakfast and lunch will be provided. Please let us know in advance if you require a special diet (i.e. diabetic, vegetarian, etc.).
5. Bring any items such as **a good book or favorite pillow** that will make your stay more comfortable. A TV is located in the patient living room for viewing. Bedtime will be no later than 11:00 PM/8:00 AM.
6. **Do not bring any jewelry or valuables with you.**

**WE REQUIRE 48 HRS. NOTICE TO CANCEL OR RESCHEDULE YOUR APPOINTMENT**  
**For any other questions call the Sleep Disorder’s Center at 727-820-7424**

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## Child/Adolescent

### SLEEP QUESTIONNAIRE

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian(s): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Please complete this questionnaire and bring it with you to the sleep study. In answering the questions be as complete as possible. The more information that is given the more complete will be the evaluation of your child's condition. **Circle** the most appropriate answers in the questionnaire.

1. Please describe in your own words as briefly as possible your child's main problem.

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2. When was the very first time this problem began? \_\_\_\_\_ years ago

3. List any medications that your child/teen is currently taking to help with the **sleep** problem:

Medication:	Dose:	Time:	How long:	Effect:	Stopped:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

4. Describe what your child/teen usually does during the last 30 minutes before bedtime:

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

5. Does your child/teen do any of the following in bed at night?

Read YES / NO

Watch TV YES / NO

Listen to the radio YES / NO

Other: \_\_\_\_\_

6. Will your child/teen fall asleep alone in bed? YES / NO

7. In order to sleep, does your child/teen often need a special toy or object? YES / NO

If so, describe: \_\_\_\_\_

8. Does your child/teen often need a bottle in order to go to sleep? YES / NO

9. What type of bed does your child sleep in?

Crib / Single bed / Double bed / Other: \_\_\_\_\_

10. Does your child sleep alone? YES / NO

If not, who with? \_\_\_\_\_

11. Which side of the body does your child/teen sleep on? Left side / Right side / Back / Face down

12. What time is the bedroom light turned off? \_\_\_\_\_ am / pm

13. Does a guardian or the child/teen turn the light off? Guardian / Child

14. Is your child/teen bothered by environmental noises? YES / NO

If so, please explain: \_\_\_\_\_

15. As an infant, was your child/teen "colicky"? YES / NO

16. As an infant, did your child/teen require any of the following devices to get to sleep?

Swing / Snuggly / Car ride / Being held / Other: \_\_\_\_\_

17. On average how long does it take your child/teen to fall asleep? \_\_\_\_\_ Hrs. \_\_\_\_\_ Min.

18. What is the quickest time it has taken your child/teen to fall asleep in the last two weeks?

\_\_\_\_\_ Hrs. \_\_\_\_\_ Min.

19. What is the longest time it has taken your child/teen to fall asleep?

\_\_\_\_\_ Hrs. \_\_\_\_\_ Min.

20. What do you think prevents your child/teen from falling asleep?

Fears / Loneliness / Not sleepy / Worries / Other: \_\_\_\_\_

21. Do you get annoyed/angry when your child/teen cannot sleep? YES / NO

22. How often does your child/teen cry him/herself to sleep? \_\_\_\_\_ times/week

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

23. Do you ever let your child/teen cry in bed in order to get to sleep? YES / NO  
If so, how long do you let the child/teen cry: 10 / 20 / 30 minutes / as long as it takes
24. When unable to fall asleep, does your child/teen get out of bed? YES / NO  
If so, how long after getting into bed: \_\_\_\_\_ Hours \_\_\_\_\_ Minutes
25. Once out of bed, what does your child/teen do? \_\_\_\_\_
26. How long is your child/teen up for? \_\_\_\_\_ Hours \_\_\_\_\_ Minutes
27. When your child/teen returns to bed, how long does it take to fall asleep again?  
\_\_\_\_\_ Hours \_\_\_\_\_ Minutes
28. If the child/teen does not get out of bed, how long does it take to fall back to sleep?  
\_\_\_\_\_ Hours \_\_\_\_\_ Minutes
29. Once having fallen asleep, how long does your child/teen sleep for? \_\_\_\_\_ Hrs. \_\_\_\_\_ Mins.
30. Does your child/teen awaken during the night? YES / NO  
If so, on average how long will your child/teen be awake for? \_\_\_\_\_ Hrs. \_\_\_\_\_ Mins.
31. How often does your child/teen awaken during the night? \_\_\_\_\_ Times
32. What time does your child/teen finally awaken in the morning/afternoon? \_\_\_\_\_ am / pm
33. What time does your child/teen get out of bed in the morning/afternoon? \_\_\_\_\_ am / pm
34. How does your child/teen seem on awakening in the morning/afternoon?  
\_\_\_\_\_  
\_\_\_\_\_
35. How does a poor nights sleep affect your child/teen the next day?  
\_\_\_\_\_  
\_\_\_\_\_
36. Does your child/teen feel sleepy during the day? YES / NO
37. Does your child/teen nap during the day? YES / NO  
If so, how often and for how long? \_\_\_\_\_
38. What time of day does your child/teen nap? \_\_\_\_\_ am \_\_\_\_\_ pm
39. If there are no naps, what time of day does your child/teen feel most tired? \_\_\_\_\_ am \_\_\_\_\_ pm
40. What time of day does your child/teen seem most alert? \_\_\_\_\_ am \_\_\_\_\_ pm
41. As the sleep period approaches, does your child/teen become more alert? YES / NO
42. Do you think a poor night's sleep effects your child's/teen's school performance the next day? YES / NO
43. Has the teacher commented on this? YES / NO

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

44. Does your child/teen toss and turn in bed? YES / NO
45. Have you ever noticed your child's/teen's head rocking from side to side at night? YES / NO  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
46. How often does this behavior occur? \_\_\_\_\_ times
47. What time of night is this activity likely to occur? \_\_\_\_\_ am/pm
48. Does your child/teen complain of aching legs at bedtime? YES / NO
49. Does your child/teen move his/her legs around in bed at night? YES / NO / Don't Know
50. Do your child's/teen's legs jerk while he/she is asleep at night? YES / NO / Don't Know
51. Does your child/teen have nightmares? YES / NO  
If so, at what age did they begin? \_\_\_\_\_ years  
How often do they occur? \_\_\_\_\_ times per night
52. Does your child/teen ever awaken suddenly with a scream and appear inconsolable?  
YES / NO / Don't Know If so, how often? \_\_\_\_\_ times per month
53. Does your child/teen sleepwalk? YES / NO If so, how often? \_\_\_\_\_ times per week
54. If your child/teen sleepwalks, has he/she ever injured him/herself? YES / NO
55. Does your child/teen ever wet the bed? YES / NO  
If so, how often? \_\_\_\_\_ times per week
56. Does your child/teen snore at night? YES / NO
57. Does the snoring occur every night? YES / NO  
If not, how often does it occur? \_\_\_\_\_ times per week
58. Does your child/teen ever seem to stop breathing while asleep? YES / NO  
If so, for how long? \_\_\_\_\_ seconds
59. Has your child/teen ever had a tonsillectomy or an adenoidectomy? YES / NO  
If so, please give the date: \_\_\_\_\_
60. Please state when your child/teen was last able to sleep consistently without any problems:  
Never / \_\_\_\_\_ years old / \_\_\_\_\_ months old
61. What time did your child/teen go to bed then? \_\_\_\_\_ pm  
How long did it take your child/teen to fall asleep? \_\_\_\_\_ hrs./min.
62. Did your child/teen awaken during the night? YES / NO  
If so, how often and for how long: \_\_\_\_\_ times \_\_\_\_\_ hrs. / mins.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

63. What time did your child/teen awaken in the morning/afternoon? \_\_\_\_\_ am
64. At what time would you like your child/teen to fall asleep now? \_\_\_\_\_ pm
65. How long would you like your child/teen to sleep for? \_\_\_\_\_ hours
66. What time would you like your child/teen to awaken in the morning? \_\_\_\_\_ am
67. For how long do you think normal children/teens of your child's/teen's age sleep? \_\_\_\_\_ hours
68. Do you consider your child's/teen's sleep problem to be: Mild / Moderate / Severe
69. Please add any other comments about your child's/teen's sleep problem that you think are relevant:

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70. Please list all people whom you have consulted about your child's/teen's sleep problem. Starting with the first, list the date, name, degree/specialty, investigations, treatment and outcome of all treatment.

**Date:** \_\_\_\_\_ **Name:** \_\_\_\_\_ **Degree/Specialty:** \_\_\_\_\_

Investigations: \_\_\_\_\_

Treatment: \_\_\_\_\_

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Degree/Specialty: \_\_\_\_\_

Investigations: \_\_\_\_\_

Treatment: \_\_\_\_\_

Investigations: \_\_\_\_\_

Treatment: \_\_\_\_\_

71. Please list all medical illness that your child/teen has been treated for in the past or is now under treatment for. *Give the date, name of illness, treatment and outcome.*

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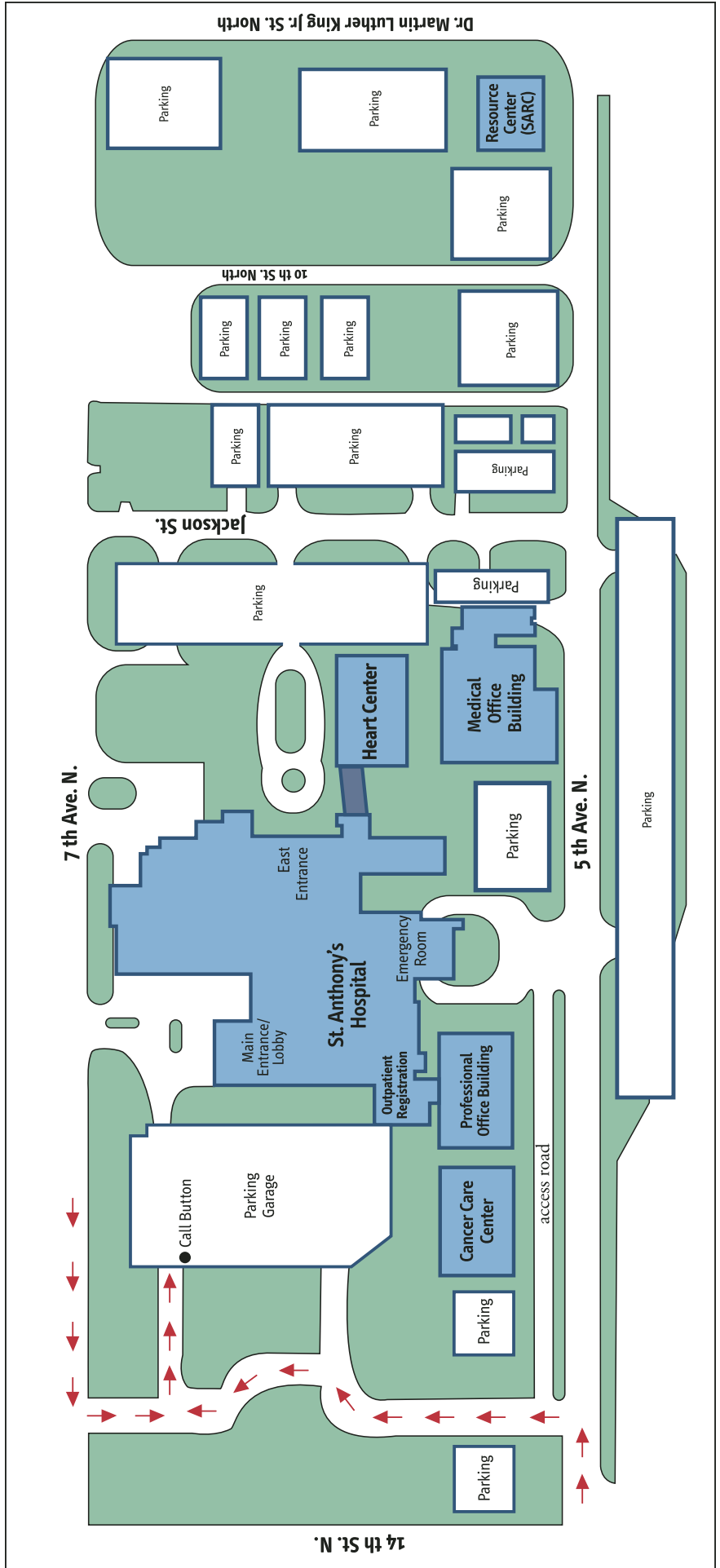
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# Sleep Disorders Center



*Driving directions on back.*

## Sleep Disorders Center—Directions

### From Tyrone Area:

- Take 5th Ave. N. headed east toward I-275.
- Follow 5th Ave. N. past I-275 and 16th St. N.
- Just past 14th St. N. is the entrance to the parking garage (on your left).
- Follow the driveway to the parking garage entrance, but do not go into the main garage entrance.
- Turn left and follow the access road to the second entrance on the right side. This is the physician's parking entrance.

### From South Pinellas:

- Take Dr. Martin Luther King Jr. Street north.
- Turn left onto 5th Ave. N.
- Just past the Emergency Department entrance you will approach the Cancer Care Center entrance.
- Turn right into the Cancer Care parking lot entrance.
- Follow the driveway back to the parking garage entrance, but DO NOT go into the main garage entrance.
- Turn left and follow the access road to the second entrance on the right side. This is the physician's parking entrance.

### From Gandy Area:

- Travel across the Gandy Bridge headed west toward St. Petersburg.
- Turn left onto 4th St. traveling south.
- Turn right onto 5th Ave. N.
- Follow 5th Ave. N. past Dr. Martin Luther King Jr. Blvd. and Jackson St.
- Just past the Emergency Department entrance, you will approach the Cancer Care Center exit.
- Turn right into the Cancer Care parking lot entrance.
- Follow the driveway to the parking garage entrance, but do not go into the main garage entrance.
- Turn left and follow the access road to the second entrance on the right side. This is the physician's parking entrance.

### From Tampa:

- Take I-275 South (over the Howard Frankland Bridge) to the 5th Ave. N. exit (#23B).
- At the end of the ramp, head east (left) on 5th Ave. N.
- Continue on 5th Ave. N. past 16th St. N.
- Just past 14th St. N. turn left into the Cancer Care parking lot entrance.
- Follow the driveway to the parking garage entrance, but do not go into the main garage entrance.
- Turn left and follow the access road to the second entrance on the right side. This is the physician's parking entrance.

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1. Enter the UNDERGROUND Parking Garage on 7th Avenue (not the main entrance in front but the back entrance of the garage). There is a blue sign that reads "Physician's Parking". You must stop at the gate and press the white button.
  2. If an operator asks you to identify yourself, respond by telling them who you are and that you are here for a sleep study. If you are not asked to identify yourself and the entrance arm raises, enter the garage and drive forward and turn right at the last row.
  3. Park near the CENTER entrance to the hospital. You may park in the Parking Area Reserved for Physicians.
  4. DO NOT use the elevators at the far end of the parking garage. You must enter at the Center entrance on the ground level. There will be a sign that reads "Sleep Disorders Center".

The Sleep Technologist will meet you at the double doors.

If the technologist is not there, call 820-7424 and inform the technologist that you are here.