UCLA Health System

Sleep Disorders Center
10833 Le Conte Ave., BE Level
Los Angeles, CA 90095
1-310-267-5337 Phone
1-310-267-1038 After hours

MRN:
Patient Name:

(Patient Label)

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 Health System

Sleep Disorders Center
10833 Le Conte Avenue, B Level
Los Angeles, CA 90095
1-310-26SLEEP (7-5337)

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.
- 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.
- 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.
- All electrodes and sensors are placed using hypoallergenic tape. Please let us know if your child has a known skin allergy.
- 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.
- The technologists are awake all night and you may call them if you need them.
- Video monitoring is done 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 are not provided. Please bring a lunch-sized cooler for your food items. We do not have a refrigerator for patient food..
- The technologists are highly trained and knowledgeable; however, they may not give you any information regarding the sleep study results or medical condition(s).
- Results will be available in approximately two weeks, and may be discussed in detail with your physician.
- 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.
- 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.

UCLA Health System

MRN:
Patient Name:

(Patient Label)

CHILD'S NAME: _____ **DOB:** _____

AGE: _____ **Years,** _____ **months** **Height:**_____ **Weight** _____

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:

_____
_____

UCLA Health System

MRN:
Patient Name:

(Patient Label)

4. DEVELOPMENT

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? _____
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

Name	Age	Brother/ sister	Specific health condition (please specify)

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:
_____
_____

UCLA Health System

MRN:
Patient Name:

(Patient Label)

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) _____

_____ poor or double vision
_____ speech/ language problems
_____ incoordination/ clumsiness
_____ hyperactivity
_____ seizures or convulsions
_____ a problem with stomach/ intestines
_____ a problem with kidneys or bladder

8. MEDICATIONS

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

	Medication	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

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 Health System

MRN:
Patient Name:

(Patient Label)

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:

	Frequency		
___sleep walking	_____	snoring/ choking	_____
___sleep talking	_____	mouth breathing	_____
___nocturnal seizures	_____	pauses in breathing	_____
___bedwetting	_____	asthma attacks at night	_____
___grinding teeth	_____		
___nocturnal pain	_____	restless sleeper	_____
___sleep paralysis	_____	light sleeper	_____
___nightmares	_____	heavy sleeper	_____
___difficulty awakening in am	_____	depressed mood	_____
___awakening too early	_____	behavior problems	_____
___disturb other's sleep	_____	learning problems	_____
___sleepy in school	_____	peer interactions	
___irritable in daytime	_____	problematic	_____
___day time spells	_____		
___impulsive	_____	short attention span	_____

UCLA Health System

MRN:
Patient Name:

(Patient Label)

OUTPATIENT NOTES

Medical Records

Person completing these forms: _____ Relationship to patient: _____

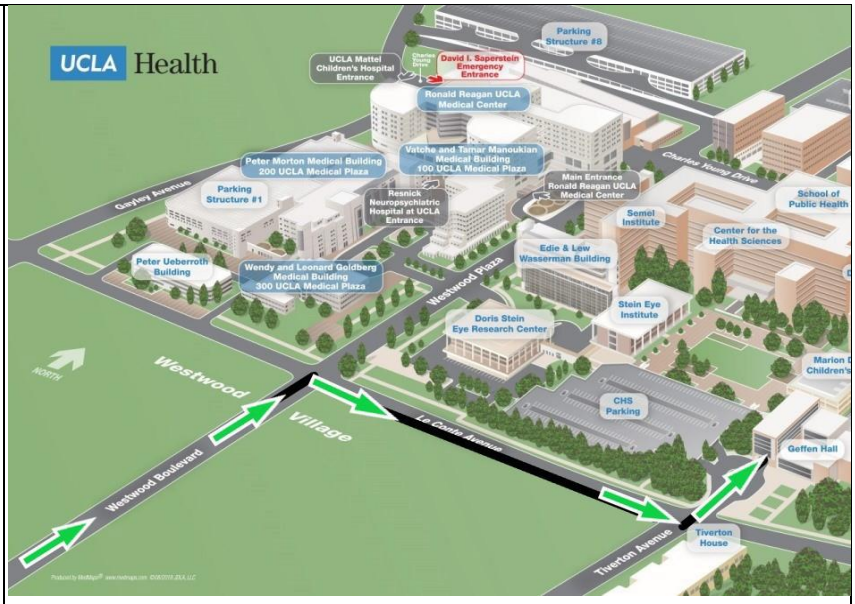
The above information -- Past medical history, family history, social history and review of systems-- may be obtained as a questionnaire completed by the patient, relatives or ancillary staff provided that it is signed and dated by the treating physician. (Reference may later be made to this information by a signed and dated statement by the treating physician, designating location of the information, date obtained and any subsequent changes.)

UCLA Health System

Sleep Disorders Center
10833 Le Conte Ave., BE Level
Los Angeles, CA 90095
310-26-SLEEP (7-5337)

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



- **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 pay station.**

For 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 $17
All Night $12
3 Hours $13
2 Hours $9
1 Hour $5