UB|MD PEDIATRICS

SLEEP CENTER

AASM 2022 ACCREDITED Facility Member

MEET YOUR SLEEP TEAM

DOCTORS: EVALUATE, DISCUSS SLEEP STUDY, CPAP OR MEDICATIONS

LOCATIONS: Pediatric Sleep Medicine Clinics

Downtown: Conventus Building, 1001 Main Street, 4th Floor, Buffalo, NY 14203

Amherst: 1404 Sweet Home Rd, Suite 5, Amherst, NY 14228

This team of providers at the UBMD Pediatrics Sleep Center will oversee your medical care and be available to you to ensure you have the best experience during your evaluation and management of your sleep problems.

They can be contacted at sleep@upa.chob.edu or 716-323-0370

Dr. Alberto Monegro

Dr. Amanda Hassinger

SLEEP STUDIES:

LOCATION: Pediatric Sleep Lab in John R. Oishei Children's Hospital (818 Ellicott Street, 2nd Floor, Buffalo, NY 14203)

We perform the prior authorization, scheduling of the study, insurance issues and submitting testing reports to your primary care doctor or other specialty providers.

CPAP: DURABLE MEDICAL EQUIPMENT (DME) COMPANIES

They are the supply company of your choosing that will help you obtain a comfortable mask and appropriate machine, if indicated.

They are your resource in obtaining repair or replacements of supplies, such as tubing.

Below are examples of DME companies in the area:

Respiratory Services of WNY
716.683.2299

Buffalo CPAP
716.206.0208

C-Pap Xpress
716.633.2788

Health System Services
716.283.4879

Pro2 LLC
716.667.9600

Sheridan Surgical
716.836.8780

ADDITIONAL PROVIDERS FROM OTHER SPECIALTIES

Often we work as a team with other health care providers who may also be involved in your sleep. These specialties include:

Dentistry—> oral devices
Ear, Nose & Throat (ENT) —> surgery
Gastroenterology & Nutrition
Genetics
Oral and Maxillofacial Surgery
Plastic Surgery
Primary Care
Psychiatry —> insomnia
Psychology —> insomnia
Pulmonology
Robert Warner Center
Speech Therapy

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Welcome to the **UBMD Pediatrics Sleep Center**, which is part of the Division of Pulmonology & Sleep Medicine. We are the *only* pediatric-dedicated sleep program in Western New York serving , infants, children and adolescents. We are devoted to improving the sleep health of all we serve!

SLEEP CENTER COMPONENTS

SLEEP CLINIC
Staffed by board certified sleep physicians in two locations*

- Full evaluation of sleep
- Examination and diagnostic planning
- Preparation for a sleep study
- Review of the sleep study results
- Treatment of sleep disorders

SLEEP LAB
Staffed by sleep technicians specializing in children's sleep studies to diagnose and treat

- Sleep apnea
- Sleep walking/talking, night terrors, rocking
- Narcolepsy
- Circadian rhythm issues

SLEEP TREATMENTS
The center will coordinate the plan including:

- Behavioral interventions
- Medications
- Surgical referrals
- Continuous or biphasic positive airway pressure machines (CPAP, BPAP)
- Light therapy

Some things a Pediatric Sleep Medicine Doctor helps with:

1. Difficulty falling asleep or staying asleep
2. Overactive or hyperactive during the day
3. Gaining too much or too little weight
4. Recurrent ear infections or sniffling
5. Prolonged or new bed-wetting
6. Behavioral problems in school
7. Night terrors, sleep walking or talking
8. Waking up cranky and irritable

Any concerns about how your child sleeps or doesn't sleep.

Locations	Contact Information	About Us
Pediatric Sleep Clinic Conventus 1001 Main Street, 4th Floor Buffalo, NY 14203 University Commons 1404 Sweet Home Road Suite 5 Amherst, NY 14228 **Pediatric Sleep Lab** Oishei Children's Hospital 818 Ellicott Street, 2nd Floor Buffalo, NY 14203	**716.323.0370** **716.323.0296** **UBMDPediatrics.com**	UBMD Pediatrics is one of 18 practice plans within UBMD Physicians' Group. We provide premier health care to infants, children, adolescents, and young adults throughout Western New York and beyond. Our doctors make up the academic teaching faculty within the Department of Pediatrics at the Jacobs School of Medicine and Biomedical Sciences at the University at Buffalo and are also the physicians at Oishei Children's Hospital.

Date: _____

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PEDIATRIC SLEEP QUESTIONNAIRE for NEW PATIENTS

Please answer the following questions by filling in the blanks or checking the appropriate responses. You may omit questions that you do not feel like they apply to your child or that you do not wish to answer. Your cooperation is appreciated and your confidentiality assured.

Child's Name: _____ Sex: M_____ F_____

Birthdate: _____ Age: _____ Height: _____ Weight: _____

Address: _____

_____

Primary phone: _____ Alternate phone: _____

Email address: _____

REFERRING PHYSICIAN

Name: _____

Address: _____

Phone Number: ( ) _____Fax Number: ( ) _____

List here any other provider that you would like us send a copy of your report:

Name: _____

Address: _____

SLEEP HISTORY

Please describe the reason you sought or are seeking this evaluation for your child:

_____

Has your child had a previous sleep study? ☐ Yes ☐ No

If yes, where was the study done? _____ Date of the study: _____

Has your child had an ENT evaluation? ☐ Yes ☐ No. Name of ENT: _____

Has your child ever had an adenoidectomy/tonsillectomy? ☐ Yes ☐ No; Date: _____

What time does your child get into bed on school days? _____ Weekends? _____

What time does your child wake up on weekdays? _____ Weekends? _____

How long does your child read, watch TV, etc after getting into bed? ____minutes

How long does it usually take your child to fall asleep? _____minutes

On an average night, how many times does your child wake up before morning?
☐ 0 ☐ 1-2 times ☐ 3-4 times ☐ More than 4 times

If your child does wake up during the night, how long does it take for him/her to go back to sleep?
☐ Less than 10 minutes ☐ 10-30 minutes ☐ 30-60 minutes ☐ Over 1 hour

How many days a week does your child wake up early and can't go back to sleep?
☐ None ☐ 1-2 days/week ☐ 3-4 days/week ☐ Over 5 days per week

How many nights a week does your child sleep in the same room as you or another primary caretaker?
☐ None ☐ 1-2 days/week ☐ 3-4 days/week ☐ Over 5 days per week

How often does your child take naps or fall asleep during the day?
☐ None ☐ 1-2 days/week ☐ 3-4 days/week ☐ Over 5 days per week

If your child naps, how long do the naps last?
☐ 10-30 minutes ☐ 30-60 minutes ☐ 1-2 hours ☐ Over 2 hours

What have you seen your child do while they are asleep?

	No	Yes	Days per week	If yes, age of onset
Does your child **snore**?				
Does your child **drool** at night?				
Is he/she a **restless sleeper**?				
Does he/she **move or kick their legs** a lot while asleep?				
Does he/she **grind their teeth** while asleep?				
Does he/she **sweat** in their sleep?				
Any **body rocking/head banging**?				
Any **bed-wetting** (if potty trained)?				

Has your child been diagnosed with any of these medical conditions?

	No	Yes	If yes, age of onset	Any treatment or surgery?
Enlarged tonsils and/or adenoids				
Nasal allergies/congestion				
Asthma				
Frequent ear infections				
Frequent morning headaches				
Too much or too little weight gain				
Stomach acid reflux (GER)				
Neurologic or Muscular disorder				

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Genetic disease				
Craniofacial disorder				
Developmental delay or learning problems				
Recent decrease in school performance				
ANY OTHER MEDICAL PROBLEMS?				

MEDICATIONS

Please list any prescription or non-prescription medications (including things to help them sleep) your child is taking:

Medication Name	Amount	How often?

Epworth Sleepiness Scale

Think of your usual way of life in recent times even if you have not done some of these things recently.

How likely is it for your child to <u>doze off</u> or <u>fall asleep</u> in the following situations?	**Never** fall asleep	**Slight** chance of sleep	**Moderate** chance of sleep	**High** chance of sleep
1. Sitting and reading (or being read to)	0	1	2	3
2. Watching television (or a computer)	0	1	2	3
3. Sitting inactive in a public place (i.e. movie theater, waiting room)	0	1	2	3
4. Riding in a car for 1 hour or more	0	1	2	3
5. Lying down to rest outside of nap time	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after a meal	0	1	2	3
8. Doing school work or taking a test	0	1	2	3

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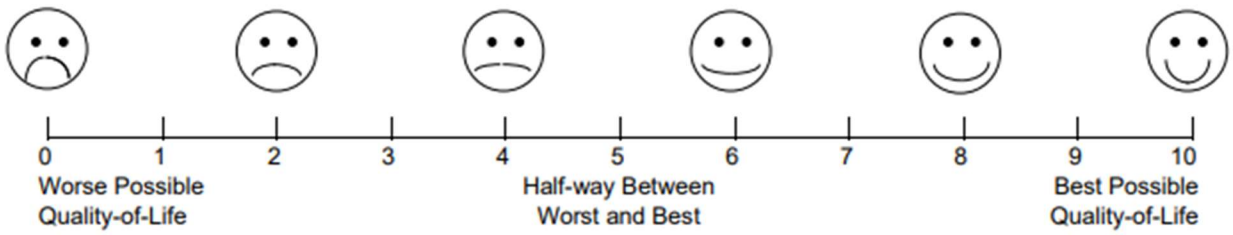
OSA-18 Quality of Life Survey

For each question below, check the box that best described how often each symptom or problem has occurred in your child in the LAST MONTH.

In the **LAST MONTH**, how often has your child had	Never	Hardy at all	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
…loud snoring?							
…breath-holding or pauses in breathing at night?							
…choking or gasping sounds while asleep?							
…restlessness or frequent awakening from sleep?							
…mouth breathing because of nasal obstruction?							
…frequent colds or upper respiratory infections?							
…nasal discharge or runny nose?							
…difficulty in swallowing foods?							
…mood swings or temper tantrums?							
…aggressive or hyperactive behaviors?							
…discipline problems?							
…excessive daytime sleepiness or drowsiness?							
…poor attention span or concentration?							
…difficulty getting out of bed in the morning?							
CAREGIVERS: In the LAST MONTH, how often have these problems in your child….							
…caused YOU to worry about your child's general health?							
…caused concern that your child is not getting enough air?							
…interfered with YOUR ability to perform daily activities?							
…made YOU frustrated?							

OVERALL, HOW WOULD YOU RATE YOUR CHILD'S QUALITY OF LIFE AS A RESULT OF THE ABOVE PROBLEMS?
(Circle one number)



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