

Consent to Obtain Medical Records:

I hereby authorize The Sleep Disorders Center of Northeast Georgia Medical Center to obtain medical records from or release medical records to any other physician, home healthcare company, insurance company or medical facility necessary in the course of my treatment.

Parent/Guardian

Signature: _____ Date: _____

Consent to Release Medical Information and/or Records to a Spouse, Family Member or Significant Other:

I hereby authorize The Sleep Disorders Center of Northeast Georgia Medical Center to release any information contained in my medical record to the person or persons listed:

1) _____ 2) _____ 3) _____

Parent/Guardian

Signature: _____ Date: _____

I do not authorize any information to be released to anyone other than myself:

Parent/Guardian

Signature: _____ Date: _____

I hereby authorize messages to be left on a voice mail system or answering machine. Please indicate the number(s) staff can utilize to leave a message for you:

1) _____ 2) _____ 3) _____

Parent/Guardian

Signature: _____ Date: _____

May we contact you at work? Yes No

I acknowledge I have read the above, am giving my consent to the above and am acknowledging I have been informed of my rights to privacy:

Parent/Guardian

Signature: _____ Date: _____



**SLEEP DISORDERS CENTER
PEDIATRIC CONSENT /
AUTHORIZATIONS**



PATIENT IDENTIFICATION:

USE BLUE OR BLACK INK ONLY

The purpose of this questionnaire is to determine the nature of your sleep problem. It is very important to be as accurate as possible in answering the questions. Your bed partner may be able to assist you.

***Please remember to write your name at the top of each page.**

This information will become part of your medical record and will remain confidential.

GENERAL INFORMATION:

Date questionnaire completed: _____
(Month/Day/Year)

Child's Name: _____
Last First MI

Parent/Guardian Name: _____

Address: _____
Street

City State Zip Code

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone/Pager: (____) _____ May we call you at work? _____

May we email you? _____ Email address: _____

What is the best way to reach you during the day? _____

Child's Birth date: ____/____/____ Age: _____ Sex: _____ Race: _____

Child's Height: _____ Weight: _____ School Grade: _____ Child's SSN: _____

Contact in case of emergency: _____

Phone: _____

Referring Physician: _____ Phone #: _____

Primary Physician: _____ Phone #: _____

REVIEWED BY: _____ **DATE:** _____

REVIEWED BY: _____ **DATE:** _____



**PEDIATRIC
SLEEP HISTORY QUESTIONNAIRE**

PATIENT IDENTIFICATION:

Current Sleep Symptoms:

Difficulty breathing when asleep?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Stops breathing during sleep?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Snores?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Restless sleep?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Sweating when sleeping?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Daytime sleepiness?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Poor appetite?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Nightmares?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Sleepwalking?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Sleeptalking?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Screaming during sleep?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Leg(s) kicking during sleep?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Waking up at night?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Getting out of bed at night?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Trouble staying in his/her bed?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Resistance going to bed?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Teeth grinding?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Uncomfortable "creepy-crawly" feeling in his/her legs?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Bed wetting?	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently

OTHER COMMENTS:

Medical and Surgical History	Date Diagnosed	Physician	Current Treatment
Mental Health <hr/> <hr/> <hr/>			
Eyes, Ears, Nose, Throat, or Mouth <hr/> <hr/> <hr/>			
Heart, Circulation, Blood, Hypertension <hr/> <hr/> <hr/>			
Lungs, Breathing <hr/> <hr/> <hr/>			
Stomach, Digestive Tract <hr/> <hr/> <hr/>			
Head or Nervous System <hr/> <hr/> <hr/>			
Other (Diabetes, Hormone, ETC.) <hr/> <hr/> <hr/>			
<hr/> <hr/> <hr/>			



**PEDIATRIC
SLEEP HISTORY QUESTIONNAIRE**

PATIENT IDENTIFICATION:

List medications the child is currently taking. (Please include prescription and non-prescription medications of all types, including sleep and non-sleep related. Also indicate if he/she is on supplemental oxygen.)

NAME OF MEDICATION	DOSAGE	HOW OFTEN	REASON

Sleep Habits:

What time does the child usually go to bed? _____ week days _____ weekends
 What time does the child usually wake up? _____ week days _____ weekends
 How long does it take the child to fall asleep? _____
 How many times does the child typically wake up at night? _____
 On average, how long does the child stay awake, once awakened? _____

General Sleep Information:

How many of the following does the child consume in a day:

Coffee _____ Tea _____ Caffeinated Soda _____

Do you, or anyone else in the house use tobacco? Yes No How long? _____
 Is there a regular bedtime routine for all residents in your home? Yes No
 Does the child have his/her own bedroom? Yes No
 Is there a parent present when the child falls asleep? Yes No
 Does the child resist going to bed? Yes No
 Does the child have difficulty falling asleep? Yes No
 Does the child awaken during the night? Yes No If yes, how often? _____
 Is this a problem? Yes No
 If awakening at night, does the child have difficulty returning to sleep? Yes No
 Is the child difficult to awaken in the morning? Yes No
 Is the child a poor sleeper? Yes No

PATIENT IDENTIFICATION:



**PEDIATRIC
SLEEP HISTORY QUESTIONNAIRE**

Are you getting a good night's sleep?

Studies show that more than 100 million Americans of all ages regularly fail to get a good night's sleep. There are at least 84 identified sleep disorders, all of which can lead to a lowered quality of life and reduced personal health. To find out if your child has a sleep disorder, have him/her answer the following questionnaire:

How likely are you to doze or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

- 0 = Never
- 1 = Seldom
- 2 = Sometimes
- 3 = Often, Frequently
- 4 = Very often, Always

How often do you fall asleep or get drowsy during class?	_____
How often do you get sleepy or drowsy while doing your homework?	_____
*Are you usually alert during most of the day?	_____
How often are you ever tired and grumpy during the day?	_____
How often do you have trouble getting out of bed in the morning?	_____
How often do you fall back to sleep after being awakened in the morning?	_____
How often do you need someone to awaken you in the morning?	_____
How often do you think that you need more sleep?	_____
*Reverse score this item	TOTAL _____



The Sleep Disorders Center of
Northeast Georgia Medical Center
770-219-6263 or 1-800-282-0535, ext. 96263

INSURANCE INFORMATION

Medical Record Reviewed by:

Initial: _____ Date: _____

Name: _____ Date: ____ / ____ / ____

PLEASE CHECK THE TYPE OF INSURANCE YOU CURRENTLY HAVE AND LIST NUMBERS AND DATES AS REQUESTED. THIS WILL HELP EXPEDITE THE PROCESS OF VERIFYING AND GETTING PRECERTIFICATION NUMBERS AS NEEDED.

.....
PRIMARY INSURANCE _____

NAME OF PRIMARY INSURED _____

ID NUMBER _____

GROUP NAME & NUMBER _____
.....

SECONDARY INSURANCE _____

NAME OF PRIMARY INSURED _____

ID NUMBER _____

GROUP NAME & NUMBER _____
.....

MEDICARE NUMBER _____

EFFECTIVE DATE _____

DATE OF RETIREMENT _____
.....

MEDICAID / GA BETTER HEALTH CARE NUMBER _____

PHYSICIAN NAME & PHONE # _____
.....

PEACHCARE FOR KIDS NUMBER _____

PHYSICIAN NAME & PHONE # _____
.....

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE SLEEP DISORDERS CENTER OF GEORGIA AT (770) 219-6263 OR OUR PRECERTIFICATION DEPARTMENT AT (770) 503-1889.



PEDIATRIC SLEEP HISTORY QUESTIONNAIRE

PATIENT IDENTIFICATION: