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: _____

Interpreter Number: _____ **Interpreter Signature:** _____

PROOF

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:** _____

PROOF

PATIENT IDENTIFICATION:

Describe child's sleep problems: _____

When did your child's sleep problems start?: _____

Has your child received any treatments or previous sleep studies? If so, where?: _____

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Northeast Georgia Medical Center

PATIENT IDENTIFICATION:

PEDIATRIC
SLEEP HISTORY QUESTIONNAIRE

NGMC FORM # 203245-02909 (6/3/24)

Current Sleep Symptoms:

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

OTHER COMMENTS:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PROOF

PATIENT IDENTIFICATION:

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

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Northeast Georgia Medical Center

PATIENT IDENTIFICATION:

PEDIATRIC
SLEEP HISTORY QUESTIONNAIRE

NGMC FORM # 203245-02909 (6/3/24)

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	

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Northeast Georgia Medical Center

PATIENT IDENTIFICATION:

PEDIATRIC
SLEEP HISTORY QUESTIONNAIRE

NGMC FORM # 203245-02909 (6/3/24)

Date: ___ / ___ / ___ Patient Name: _____ Age: _____

SLEEP REVIEW OF SYSTEMS

Current Daytime Symptoms:
Please check best answer on each symptom.

Trouble getting up in the morning?	❑ never	❑ occasionally	❑ frequently
Falls asleep at school?	❑ never	❑ occasionally	❑ frequently
Naps after school?	❑ never	❑ occasionally	❑ frequently
Daytime sleepiness?	❑ never	❑ occasionally	❑ frequently
Feels weak or loses control of his/her muscles with strong emotions?	❑ never	❑ occasionally	❑ frequently
Reports being unable to move when falling asleep or waking?	❑ never	❑ occasionally	❑ frequently
Reports frightening visual images before falling asleep or upon awakening?	❑ never	❑ occasionally	❑ frequently

Obsessive Compulsive Disorder?	❑ Yes	❑ No
Depression?	❑ Yes	❑ No
Learning disabilities?	❑ Yes	❑ No
Drug use / abuse?	❑ Yes	❑ No
Behavioral disorder?	❑ Yes	❑ No
Placed in psychiatric care?	❑ Yes	❑ No

Psychiatric History:

Autism?	❑ Yes	❑ No
Developmental delay?	❑ Yes	❑ No
Hyperactivity / ADHD?	❑ Yes	❑ No
Anxiety / Panic attacks?	❑ Yes	❑ No

MEDICAL REVIEW OF SYSTEMS

Please check next to all statements that apply.

Recent Symptoms

Constitutional:
❑ Fever/chills ❑ Weight loss
❑ Fatigue ❑ Anxiety
❑ Depression ❑ Panic attacks

Eyes:
❑ Blurred vision ❑ Double vision

ENT:
❑ Sinus/Nasal stuffiness ❑ Nose bleeds
❑ Hoarseness ❑ Sores in mouth
❑ Difficulty swallowing

Cardiovascular:
❑ Chest pain ❑ Palpitations

Respiratory:
❑ Cough ❑ Wheezing
❑ Shortness of breath

Gastrointestinal:
❑ Heartburn ❑ Indigestion
❑ Nausea/vomiting

Genitourinary:
❑ Frequent nighttime urination

Musculoskeletal:
❑ Joint pain ❑ Joint swelling

Skin:
❑ Skin changes ❑ Dry skin
❑ Hair loss

Neurologic:
❑ Weakness ❑ Paralysis
❑ Tremor ❑ Memory loss

Endocrine:
❑ Heat or cold intolerance

Hematologic/Lymphatic:
❑ Free bleeding ❑ Blood clots

THE FOLLOWING INFORMATION TO BE COMPLETED BY STAFF ONLY:

Reviewing Physician: _____ Date: _____

Height: _____ Weight: _____ Blood Pressure: _____ BMI: _____

PROOF

Northeast Georgia Medical Center

PATIENT IDENTIFICATION:

PEDIATRIC
SLEEP HISTORY QUESTIONNAIRE

NGMC FORM # 203245-02909 (6/3/24)

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

PROOF

PATIENT IDENTIFICATION:

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.

Interpreter Number: _____ **Interpreter Signature:** _____

PROOF

Northeast Georgia Medical Center

PATIENT IDENTIFICATION:

PEDIATRIC
SLEEP HISTORY QUESTIONNAIRE

NGMC FORM # 203245-02909 (6/3/24)