Pediatric Sleep Medicine Services
Mid-South Pulmonary Specialists/Sleep Division
5050 Poplar Avenue, Suite 700
Memphis, TN 38157
901-683-0044

Dear Parents:

Welcome to the Mid-South Pulmonary Specialists/Sleep Division Center. As a pediatric sleep medicine specialists, please know that I am dedicated to providing the very best care for your child.

_______________________ **has an appointment with Dr. Wise** _________________ **at** __________ **am/pm.**

In order to make our time together in the Sleep Division Center as productive as possible, I would ask that you complete the enclosed sleep and health questionnaire, and sleep diary. This allows me to know as much as possible about your child's sleep problems, and helps me coordinate the best treatment plan for your child. The time you spend with the questionnaire will be worthwhile and may help us identify key areas that may require further discussion.

Consultation with a sleep specialists is a new experience for many families. The enclosed handout on Frequently Asked Questions will help you know what to expect during your visit to the Sleep Division Center.

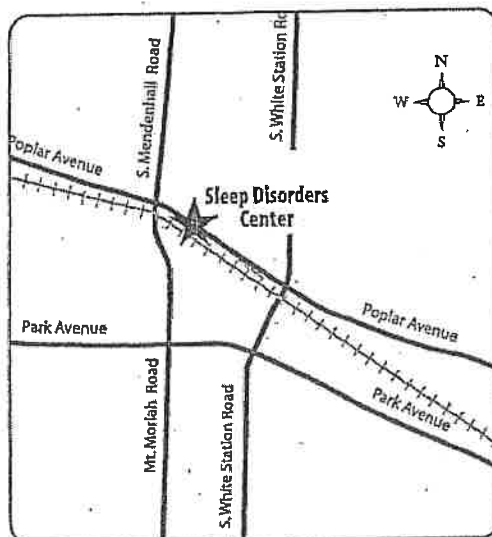
I look forward to the opportunity to meet you and your child, and to work with you to make a positive impact in your child's life. For many children with sleep problems, treatment of an underlying sleep disorder is the first step in helping the child achieve his or her greatest potential. Sometimes diagnosis and treatment of the child also leads to a better quality of life for parents, too!

RESCHEDULING: If you are unable to keep your appointment please call the Sleep Division Center at **901-276-6507** 8:00 a.m. – 4:30 p.m. at least 24 hours in advance.

Sincerely,

Merrill S. Wise, M.D.
Pediatric Sleep Medicine Specialists
Mid-South Pulmonary Specialists/Sleep Division

Enclosures: Pediatric Sleep Questionnaire
Sleep Diary
Frequently Asked Questions



5050 Poplar Avenue, Suite 700
Memphis, TN 38157
(Located in the White Station Tower)

MID-SOUTH PULMONARY SPECIALISTS/SLEEP DIVISION

5050 POPLAR AVENUE, SUITE 700
MEMPHIS, TN 38157
www.mspulmonary.com

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE

MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (If Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (If Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#	
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#	
ADDRESS OF INSURANCE COMPANY			COPAY AMT $	
CITY, STATE ZIP	PHONE		DEDUCTIBLE $	
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE

I authorize medical treatment by my physician. I agree to pay all cost associated with collecting services in the event I fail to pay the balance due. I authorize payment of Medicare/Medicaid and other health insurance benefits be made on my behalf. I authorize the release of my medical information to CMS, insurance companies or their agent all information needed to determine benefits for services rendered. This authorization remains in effect until I revoke it in writing. I have received a copy of the Mid-South Pulmonary Specialists, P.C. Notice of Privacy Practices for Health Related Information.

ARE YOU HISPANIC OR LATINO--YES/NO

SIGNATURE OF PATIENT/GUARDIAN ______________________ DATE ______________________

MID-SOUTH PULMONARY SPECIALISTS, P.C.
AUTHORIZATION FOR RELEASE OF INFORMATION

NAME: ______________________________ SS#: ______________________________

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY HEALTH INFORMATION CONTAINED IN MY MEDICAL RECORD TO THE FOLLOWING PERSONS:

____

____

I authorize the practice to disclose or provide protected health information directly to me at the email address, fax number, phone number, cell phone number, or alternative address that I have indicated below. I am also allowing Mid-South Pulmonary Specialists to leave a message on my answering machine or with the person answering the telephone regarding appointments, etc. I understand that it is my responsibility to notify the practice of my preferred method of communications or any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, and carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

☐ **Cell phone:** ☐ **email address:** ☐ **mail:** ☐ **fax number:** ☐ **other phone:** ☐ **text message:**

____

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; or, check only those items of the record to be disclosed:

☐ Office notes
☐ Lab results, pathology reports
☐ X-rays
☐ Financial history report (previous 3 yrs. only)
☐ Nursing home, home health, hospice, and other physician records
☐ Only send the following: ____

PURPOSE OF DISCLOSURE (please state the purpose of the disclosure or check patient request):

☐ **Patient Request** ☐ **Other (please specify):** ______________________________

When requesting information to be disclosed, please specify the format in which you would like the PHI provide to you. We will accommodate your request, if possible. Please be advised that there may be costs involved in providing the PHI requested.

☐ Paper copy ☐ electronic copy via the following: ☐ CD ☐ flash drive ☐ other means: ______________________

By signing below, I agree with the following information:

Expirations or termination of authorization – This authorization will need to be renewed every twelve (12) months, unless I specify an earlier termination. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date.
Please list desired expiration date: ______________________
Right to revoke or terminate: As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in-person or by mailing a written request to the practice, attn.: Compliance Office.
Non-Conditioning statement: The practice places no condition to sign this authorization on its delivery of healthcare or treatment.
Re-disclosure Statement: I understand that the practice has no control regarding persons who may have access to the mailing address, email address, telephone, cell or fax number I have designated to receive my protected health information. Therefore, I understand that my protected health information disclosed under this authorization will no longer be the responsibility of this practice.

I understand that authorizing disclosure of this health information is voluntary. I do not need to sign this form to assure treatment. HOWEVER, IF THIS AUTHORIZATION IS NEEDED FOR PARTICIPATION IN A RESEARCH STUDY, MY ENROLLMENT IN THE STUDY MAY BE DENIED. Also, if this authorization is needed for the sole purpose of creating protected health information to disclose to a third party, my treatment may be denied.

I understand I am entitled to a copy of this form. I have seen and had an opportunity to read the notice of privacy practices for health related information.

______________________________ ______________________
Signature of patient or legal representative Date

____
Relationship to patient

Pediatric Sleep Questionnaire

Mid-South Pulmonary Specialists/Sleep Division

Child's Name: ______________________ **Date of Birth:** __________ **Age:** ________ **Sex:** _____

CONTACT INFORMATION:

Home Telephone: ______________________ Mother's work or cell phone: ______________________

Father's work or cell phone: ________________ Email contact: ______________________________

Pharmacy Number: ______________________

Child's Pediatrician or Primary Care Provider: ______________________________________

Address: ____

City: ______________________________ State: ______________ Zip Code: ______________

Who referred your child for a sleep evaluation?

_______Pediatrician or Primary Care Provider
_______Teacher or School Nurse
_______Surgical Specialist, such as ENT
_______Other(specify):______________
_______Parent initiated Referral
_______Psychiatrist or Psychologist
_______Pediatric specialist, such as neonatologist, allergist, pulmonologist, neurologist, etc.

Please explain your concerns about your child's sleep:

____
____
____
____
____
____
____
____

What are your goals in coming for a sleep evaluation?

____
____
____

SLEEP PATTERNS:

What is your child's usual **bed time** on week nights? __________ Weekends or holidays? ______________
What is your child's usual **waking time** on week nights? ________ Weekends or holidays? ______________
How long does it take your child to fall asleep? ________________
How many times does your child awaken after falling asleep? __________________
Where does your child typically fall asleep? ______________ Where does your child wake up? __________
Are parents or others present as the child falls asleep? ______________________
How many naps does your child take, and what time do they occur? ______________________________

DOES YOUR CHILD EXPERIENCE: (mark all that apply)

_____Difficulty falling asleep?

_____Difficulty staying asleep?

_____Difficulty waking up in the morning?

_____Nightmares or sudden awakenings from sleep?

_____Snoring during sleep?

_____Gasping or snorting during sleep?

_____Breathing problems during sleep?

_____Periods of cessation of breathing during sleep?

_____Difficulty sleeping unless propped up on multiple pillows?

_____Uncomfortable feelings or pain in legs(creepy crawly feelings)?

_____Bedwetting? If so, how often per week? __________

_____Frequent or persistent nasal congestion or sinus problems?

_____Excessive jerks or twitches during sleep?

_____Restless sleep?

_____Kicks legs repetitively during sleep?

_____Talking during sleep?

_____Walking or running during sleep?

_____Teeth grinding during sleep (bruxism)?

_____Excessive daytime sleepiness, such as falling asleep in school?

_____Naps after school?

_____Irritability, moodiness or sudden changes in emotions?

_____Drink caffeinated beverages? How many per day?_

Has your child had a previous sleep evaluation or sleep study (explain when and where)? ______________

____

Has your child ever had:

_____Tonsillectomy (date, if known) __________

_____Adenoidectomy(date, if known) ______________

_____Ear tube placement(date, if known) __________

_____Broken nose or other nasal trauma(date,if known)____

_____Enlarged tonsils or adenoids but no surgery

Past Medical History:

Birth Weight: _______Was your child born prematurely? _______If so, what was the gestational age?______

Were there complications during pregnancy, labor or delivery(explain)? ______________________

____

____

Is your child, or has your child ever been on a home apnea monitor? ______________________

If yes, what are the current settings for apnea delay? ________ Heart rate? ______________

Is your child, or has your child ever been treated with nasal CPAP? __________________

If yes, what pressure was used? ________________________

Does your child have any allergies to medications (explain)? ______________________________

____

What medications is your child receiving on a routine basis? ______________________________

____

____

____

As needed medications: ____

____

Does your child have a history of:
(check those that apply)

_____Recurrent Headaches
_____Hearing Problems
_____Inattentiveness or easy distractibility
_____Attention Deficit Hyperactivity Disorder(ADHD)

_____Vision Problems
_____Learning disabilities
_____Hyperactivity
_____A genetic disorder that affects development such as Downs Syndrome, Prader-Willi Syndrome, Fragile-X Syndrome (specify) ______________________

_____Epilepsy (recurrent seizures)
_____History of meningitis
_____Cerebral Palsy

_____History of head trauma
_____Developmental Delay
_____Autism or Autistic Spectrum Disorder(Asperberger's Syndrome, PDD, etc.)

_____Mental Retardation
_____Gastroesophageal reflux (GER)
_____Poor weight gain or failure to thrive
_____Heart Disease(specify): ______________
_____Sickle cell disease or other blood problems

_____Asthma (reactive airways disease)
_____Recurrent ear or throat infections
_____Overweight or obesity
_____High blood pressure
_____Chronic pain syndrome such as arthritis, fibromyalgia neck or back pain, or diffuse muscle aches

_____Anxiety or panic attacks
_____Obsessive/compulsive problems

_____Depression or possible depression
_____Behavior problems such as oppositional/defiant behaviors

_____Psychological trauma such as recent loss of a loved one, divorce or separation, exposure to violence, abuse or neglect (specify): ____
_____For adolescents, history of alcohol or substance abuse
_____Other medical or psychological problems(specify): ______________________________

Educational History:

Current grade: _______ School: ______________________________ Typical grades: ____________

Does your child:
Receive any special services at school? ____

Have excessive absences or tardies? ____

Experienced areas of academic challenge or failure? ______________________________________
Family History:

	NAME:	***AGE:***	***SLEEP PROBLEMS OR DISORDERS:***
Parents:			
Brothers/Sisters:			
Grandparents:			

Is your child being followed by a:
_____Pulmonologist? _____Neurologist or Child neurologist? _____Psychologist?
_____Psychiatrist or Child psychiatrist? _____Ear, Nose & Throat Specialist(ENT)?
_____Other specialist(s)? Specify: ______________________________

INFANT and CHILD SLEEP DIARY

TWO WEEK SLEEP DIARY FOR (Name) ______________________

1. Answer the questions in the shaded areas.
2. Draw a line through the times your child was asleep (include naps). Each box represents one hour.
3. Put down arrow (↓) at the times your child went to bed and up arrow (↑) at times your child got out of bed.

Rating Scale:
1=Poor 2=Fair 3=Good

Date	Day	8:00 am	9:00 am	10:00 am	11:00 am	12:00 pm	1:00 pm	2:00 pm	3:00 pm	4:00 pm	5:00 pm	6:00 pm	7:00 pm	8:00 pm	9:00 pm	10:00 pm	11:00 pm	MIDNIGHT	1:00 am	2:00 am	3:00 am	4:00 am	5:00 am	6:00 am	7:00 am	Rate your child's quality of sleep	Rate your child's level of quality of alertness	Rate your child's mood on awakening
	Day 1																											
	Day 2																											
	Day 3																											
	Day 4																											
	Day 5																											
	Day 6																											
	Day 7																											
	Day 8																											
	Day 9																											
	Day 10																											
	Day 11																											
	Day 12																											
	Day 13																											
	Day 14																											

COMMENTS: