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.

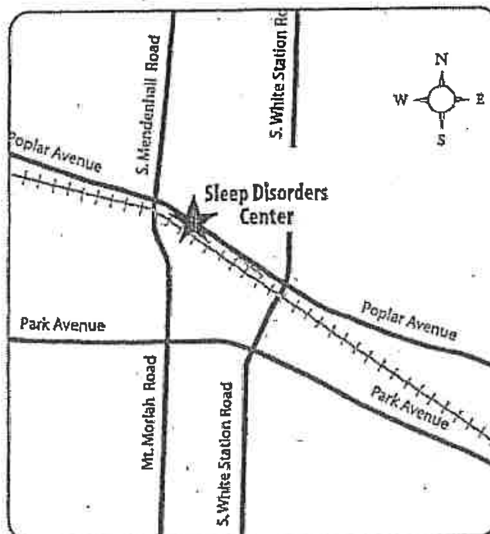
I look forward to the opportunity to meet you and your child, and to work with you to make a positive impact in your child's life. For many children with sleep problems, treatment of an underlying sleep disorder is the first step in helping the child achieve his or her greatest potential. Sometimes diagnosis 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 300
MEMPHIS, TN 38157
(901) 276-6507

PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)				
CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP		HOME PHONE		
PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN		CONTACT NAME		CONTACT 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	SECONDARY/BILLING ADDRESS (if Applicable)				
CITY, STATE ZIP	CITY, STATE ZIP				
HOME PHONE	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	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT $	
CITY, STATE ZIP	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:

____
____
____
____
____

BY SIGNING THIS FORM, I AM ALSO ALLOWING MID-SOUTH PULMONARY SPECIALISTS, P.C. TO LEAVE A MESSAGE ON MY ANSWERING MACHINE OR WITH THE PERSON ANSWERING THE TELEPHONE REGARDING APPOINTMENTS, TEST RESULTS, ETC. MID-SOUTH PULMONARY SPECIALISTS MAY ALSO SEND MY RECORDS TO OTHER PHYSICIANS UPON MY REQUEST.

PATIENT ACKNOWLEDGEMENTS:

By signing below, I agree with the following information:
I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then my not be protected by federal confidentiality rules.

I understand that I have the right to revoke this authorization at any time. Any revocation must be in writing but will not apply to information already released based on this authorization. UNLESS OTHERWISE REVOKED BY A SPECIFIC DATE REQUESTED, THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE SIGNED.

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

INFANT APNEA QUESTIONNAIRE

Methodist Healthcare Sleep Disorders Center

Child's Name: ______________________________ Age: __________

Date of Birth: ______________ Sex: ____________

Address: ____

City: __________________ State: ______________ Zip: __________

CONTACT INFORMATION:

Home Telephone: ________________ Mother's Work or Cell Phone: ______________

Father's Work or Cell Phone: _______________ Email: ______________________

Child's Pediatrician or Primary Care Provider: ________________________________

Address: ____

City: __________________ State: ______________ Zip: __________

Telephone: ______________________

Who referred your child for evaluation?

_____Pediatrician or primary care provider

_____Parent initiated referral

_____Pediatric specialist such as neonatologist, pulmonologist, neurologist, etc.

_____Surgical specialist, such as ENT specialist

_____Other (please specify): ______________________________

Please explain any concerns about your child's sleep:

____

____

PAST MEDICAL HISTORY:

Birth Weight: __________________ Location (hospital): ______________________

Was your child born prematurely? ____________ If so, what was the gestational age? __________

Was your child a "multiple?"(please circle) **Singleton** **Twin** **Triplet**

Were there any complications during pregnancy, labor, or delivery? Please explain: ______________

____

____

Did your child require respiratory support with (check all that apply):

_____Supplemental oxygen?

_____Incubation/mechanical ventilation (breathing tube and machine)?

_____Tracheostomy?

In the nursery did your child experience (check all that apply):

_____Seizures? _____Intracranial hemorrhage? _____Hydrocephalus requiring a shunt?

_____Birth asphyxia? _____Cardiopulmonary arrest? _____Meningitis or encephalitis?

Is your child currently on a home apnea monitor? YES NO

What are the current settings for the apnea delay? ______________________________

Heart rate delay? ______________________________

How often are alarms occurring over the past two weeks? ______________________________

When was the most recent alarm? ______________________________

Is your child requiring stimulation or other intervention with any recent alarms (please specify)?

____

____

Does your child experience: (check all that apply)

_____Snoring during sleep? _____Gasping or snorting during sleep? _____Breathing problems during sleep?

_____Periods of cessation of breathing during sleep? _____Restless sleep?

_____Episodes of floppiness, loss of responsiveness, or sudden change in color?

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

____

____

Describe where your child sleeps: (check all that apply)

_____Own bedroom _____Parent's bedroom_____Bassinet_____Baby bed_____Parent's bed

_____Other (please describe): ____

In what position do you place your child to sleep (please circle)?

Back Side Abdomen(stomach) It varies

Does anyone in your home smoke? YES NO

Is your child exposed to cigarette smoke? YES NO

Is there a family history of SIDS (Sudden Infant Death Syndrome)? YES NO

If yes, please describe: ______________________________

____

____

____

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

____

____

What medications is your child receiving on a routine basis?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

"As needed medications" ______________________________

____

Is your child being followed by a:

_____Pulmonologist? _____Neurologist or child neurologist? _____Ear, Nose & Throat(ENT)specialist?

_____Other specialist(s)? Please Specify: ______________________________

FAMILY HISTORY:

	Name(s)	**Age**	**Sleep Problems or Disorders?**
Parents:			
Brothers/Sisters:			
Grandparents:			