SLEEP CLINIC

Welcome to Sleep Clinic

We hope the following information will assist you with your rotation through our area.

Physicians	Specialty	Types of patients
Dr. Valerie G. Kirk	Respirologist (Director)	All patients
Dr. Michele Bjornson	Pediatrician (ED)	All patients
Dr. Monique Jericho	Pediatric Psychiatry	Behavioural sleep only
Dr. Sheldon Spier	Respirologist	OSA only
Dr. Candice Bjornson	Respirologist	OSA only

Clinic days	Times	Location
Occasional Wednesdays (check the main schedule for specific dates)	0900 – 1200	Sleep Lab
Every Thursday (check the main schedule for exceptions)	1300 – 1600	Rooms 1-4 Blue Conference Room

Dictations:
Please remember when you dictate your clinic note, write the dictation number at the top of the nursing assessment sheet and request a copy for the Sleep Clinic.

Attached is a copy of our nursing assessment sheet that might help guide you through your initial clinic assessments.

Pediatric Sleep Clinic Nursing History

DATE: _____ **Interview with**_____

Name: _____ **Age:** _____**yrs** _____**mos**
DOB: _____
ACH: _____

General History/Family History (OSA)
Color (pink – ashen gray)
Dark circles under the eyes
Growth and development (small/large for age?)

Family members with OSA?
Family history of heart disease
Are there any smokers in the home?

Current Medications:

Evening routine:

Bedtime: Weekdays_____ Weekends_____
Difficulty falling asleep?
On average, how long does it take for them to fall asleep?

What/who is in the child's bedroom?

Computer	O Yes	O No
Digital clock radio	O Yes	O No
Stereo	O Yes	O No
Ipod/Xbox/gameboys etc.	O Yes	O No
Night lights	O Yes	O No
Do they share the room/bed with a sibling?	O Yes	O No
Fears	O Yes	O No

What's happening while they sleep?

Sweating	O Yes	O No	
Bruxism	O Yes	O No	
Snoring	O Yes	O No	
Apneas (how long)	O Yes	O No	_____Seconds
Primary or Secondary Enuresis	O Yes	O No	
Do they wake up at night? (how often)	O Yes	O No	_____#/Night
Difficulty staying asleep?	O Yes	O No	
Sleep walk/talking/terrors	O Yes	O No	

Pediatric Sleep Clinic Nursing History

Awake time: Weekdays_____ Weekends_____

How difficult is it to wake the child in the morning?
Weekdays:

Weekends:

Morning behaviour/attitude?

Grumpy	O Yes	O No
Happy	O Yes	O No
Tired/listless	O Yes	O No
Non-restorative sleep	O Yes	O No
Complains of morning headaches	O Yes	O No

Daytime behaviours:
Is this child generally happy or emotionally labile?
Energy: Are they busy or lethargic during the day?
Does he/she fall asleep at school or have excessive sleepiness?
Do the teachers at school present any concerns to the family?
How is school going?

Social:
Do they generally get along with their peers?

Is the child involved in outside school activities?

Narcolepsy	PLMD related questions:
Hallucinations?	Growing Pains?
Cataplexy?	Creepy crawly's on legs?
Falls asleep anywhere any time?	
Sleep Paralysis?	

Plan:

Nursing Assessment completed by: