# Pediatric Dental Care of RI

Sleep Screening Form

PEDIATRIC DENTAL CARE OF RHODE ISLAND

Patient Name: _____DOB: _____Date: _____

**Please fill out the top part of this form and answer any sub questions that may apply:**

1. Do you notice your child still appears to be lethargic or "sleepy" when waking up in the morning? **Yes/No.** If yes, does your child frequently doze off during the day? **Yes/ No**
2. Does your child snore? **Yes/No/Unknown** If yes, do you notice "pauses" during snoring? **Yes/No**
3. Has your child been diagnosed with any behavioral issues (ex. ADHD, OCD, SPD, ODD)? **Yes/No**
    a. If yes, please write diagnosis: _____
4. Do you suspect your child has a behavioral disorder? **Yes/No**. Does it affect schoolwork? **Yes/No/n/a**
    a. What behavior concerns you? _____
5. Does your child wet the bed? **Yes/No/Infant.** If yes, what is the frequency? **Rarely/Weekly/Daily**
6. Do you notice your child "gasping" or "squeaking" during sleep? **Yes/No/Unknown**
7. Does your child have nightmares/night terrors? **Yes/No/Unknown**. If yes, frequency? **Rare/Often**
8. Do you notice your child sweats while sleeping? **Yes/No.** If yes, is it: **Mild/Moderate/Severe**
9. Does your child primarily breathe through his/her mouth? **Yes/No/Unknown**
10. Do you notice your child sleeping in abnormal positions? **Yes/No/Unknown _____**

I understand that the information I have given is correct to the best of my knowledge, that it will be held in strict confidence. I authorize the dental staff to share any relevant information provided above to my child's primary care provider. I will not hold my dentist, or any member of his staff responsible for any errors or omissions that I may have made in completing this form.

Signature of Parent/ Legal Guardian: _____ Date: _____

---

**For Clinical Use Only:**

Professional observations of OCS and OSA screening:

(Check ALL that apply)

| | | | |
|---|---|---|---|
| | Attrition (Mild/Moderate/Severe) | | Hyperactivity/Irritability/Unable to sit still for Tx. |
| | Vaulted Palate (Mild/Moderate/Severe) | | Retrognathic (recessed) Chin |
| | BMI (WNL/not WNL) | | Small/Triangular Chin |
| | Class 2 Occlusion | | Mouth Breathing |
| | Enlarged Tonsils | | Eczema/Asthma/Breathing issues |
| | Allergy Shiners present | | |

Signature of Dentist/RDH_____