PEDIATRIC SLEEP ASSOCIATES
Pediatric Needs Assessment

1) Name: _____________________________Age: _______

2) Home Respiratory Arrangement:
   □ Nothing used
   □ Oxygen
   □ CPAP: Setting: _____ cm of water
   □ Bi-level: Setting: ___ / ___ cm of water
   □ Other: _______________________________________

3) Tracheostomy: □ Yes □ No

   If Yes, Study to be run: □ Uncapped Tube □ Capped Tube □ Split Night
   (Split night: First half capped, second half uncapped)

   Primary Goal of the Trach Tube Study:
   a) Assess whether the trach tube is functioning correctly
   b) Assess whether patient needs ventilation via trach tube
   c) Assess if the trach can be removed in the future (capped study)
   d) Other : _____________________________________________

4) Developmental Delay: □ Yes □ No

   If Yes, Severity: □ Mild □ Moderate □ Severe

5) Developmental/Behavioral Problem (e.g., Down's, Autism, ADHD): □ Yes □ No

   If Yes, Type of Behavior:______________________________________________
   ________________________________________________________________

6) Seizures: □ Yes □ No

   If Yes: Frequency: ____________________________
   Type: ________________________________________

7) Other Special Needs / Concerns:
   □ Wheelchair
   □ Feeding Tube
   □ Non-English Speaker / Interpreter Needed
   □ Other: ____________________________________________________________