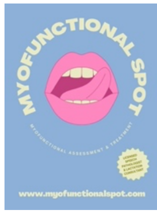

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BEBID SLEEP SCREENING ALGORITHM

Name: ___________________________ Date: ____________

The "BEBID" instrument is divided into five major sleep domains, providing a comprehensive screen for the major sleep disorders affecting children in the 2- to 18-year old range. Each sleep domain has a set of "trigger questions" for use in the clinical interview.

B = bedtime problems
E = efficiency of sleep
B = breathing
I = interruptions of sleep
D = daytime irregularities

Please indicate "yes" or "no" for each question and provide additional information if needed.

Bedtime Problems:

1. Does your child have difficulty **getting** to sleep? __ Yes __ No ________________
2. Does your child have difficulty **staying** asleep? __ Yes __ No ________________
3. Does your child wake up then have trouble going back to sleep? __ Yes __ No ________________
4. Does your child sleep lightly and are they easily roused? __ Yes __ No ________________

Efficiency of sleep:

1. When sleeping, does your child ever appear to stop breathing? __ Yes __ No ________________
2. When sleeping, does your child ever hasp or wake with a startle? __ Yes __ No ________________
3. When sleeping, does your child's ever end up in odd positions? __ Yes __ No ________________
4. When sleeping, does your child sweat more than usual? __ Yes __ No ________________
5. When sleeping, does your child leave drool on the pillow? __ Yes __ No ________________
6. Does your child toss and turn while asleep? __ Yes __ No ________________
7. Does your child wake up in a tangle of bedclothes or on the wrong side of the bed? __ Yes __ No ________________
8. Does your child receive the recommended amount of sleep for their age, if not then how many hours do they sleep? __ Yes __ No ________________
9. When sleeping does your child grind their teeth? __ Yes __ No ________________

Breathing:

1. When sleeping, does your child have their head extended back? __ Yes __ No __________________

2. Does your child chew with his mouth open / messy eater? __ Yes __ No __________________

Interruptions of sleep:

1. Does your child have nightmares? __ Yes __ No __________________

2. Does your child sleepwalk or talk? __ Yes __ No __________________

Daytime irregularities:

1. Does your child wake up groggy and / or moody? __ Yes __ No __________________

2. Does your child wake up with a headache? __ Yes __ No __________________

3. Does your child appear lethargic or hyperactive during the day? __ Yes __ No __________________

4. Does your child exhibit thumb sucking or chewing on foreign objects? __ Yes __ No __________________

National Sleep Foundation Recommended Sleep Times

Toddlers *(1 - 2 years)*	11 - 14 hours
Preschoolers *(3 - 5 years)*	10 - 13 hours
School age children *(6 - 13 years)*	9 - 11 hours
Teenagers *(14 - 17 years)*	8 - 9 hours

I have truthfully answered all of the above questions and agree to inform your practice of any changes in my child's medical history, in addition, I certify that I have custody to do authorize informed consent for the practice to perform complete medical, dental, and / or myofunctional evaluations of the patient.

____

Parent / Guardian Name

____

Signature

____ / ____ / _______

Date

('Adapted from the SSSRR Sleep History Screening© 2018' and 'BEARS Sleep Screening Algorithm')