# PROMIS Sleep Disturbance Discharge Assessment - Caregiver

***(Please note all PROMIS assessments completed on paper must be entered online.)***

Client Name: _________________________ Date: ______________

The questions below ask about the quality of your child's sleep in the past week.

| **In the past seven days:** | | | | | | **Clinician Use** | |
|---|---|---|---|---|---|---|---|
| | Not at all | A little bit | Somewhat | Quite a bit | Very Much | Item answered? (Put a 1 if item was answered) | Item Score |
| His/her sleep was restless. | O 1 | O 2 | O 3 | O 4 | O 5 | | |
| He/she was satisfied with his/her sleep. | O 5 | O 4 | O 3 | O 2 | O 1 | | |
| His/her sleep was refreshing. | O 5 | O 4 | O 3 | O 2 | O 1 | | |
| He/she had difficulty falling asleep. | O 1 | O 2 | O 3 | O 4 | O 5 | | |

| **In the past seven days:** | | | | | | **Clinician Use** | |
|---|---|---|---|---|---|---|---|
| | Never | Rarely | Sometimes | Often | Always | Item answered? (Put a 1 if item was answered) | Item Score |
| He/she had trouble staying asleep. | O 1 | O 2 | O 3 | O 4 | O 5 | | |
| He/she had trouble sleeping. | O 1 | O 2 | O 3 | O 4 | O 5 | | |
| He/she got enough sleep. | O 5 | O 4 | O 3 | O 2 | O 1 | | |

*Measure adapted from PROMIS—Sleep Disturbance—Short Form © 2008-2013: American Psychiatric Association, PROMIS Health Organization, and PROMIS Cooperative Group.*

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| In the past seven days: | | | | | | Clinician Use | |
|---|---|---|---|---|---|---|---|
| | Very Poor | Poor | Fair | Good | Very Good | Item answered? (Put a 1 if item was answered) | Item Score |
| His/her sleep quality was… | O 5 | O 4 | O 3 | O 2 | O 1 | | |

**In the past seven days, has your child taken any medication that impacted your child's sleep?**

O Yes

O No

↳ *For those who answered "Yes" to the above:*

**Was the medication prescribed by a doctor?**

O Yes

O No

**Does your child have a physical health condition that is currently impacting your child's sleep?**

O Yes

O No

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**Did you complete the Sleep Hygiene Checklist on behalf of your child?**

- O Yes
- O No

*For those who answered "Yes" to the above:*

**What new actions did your child try?**

| | |
|---|---|
| ☐ | Exercise at least 20-30 minutes each day |
| ☐ | Avoid exercising in the three hours before bed |
| ☐ | Avoid naps |
| ☐ | Go to bed and wake up at the same time each day including weekends |
| ☐ | Keep my bedroom dark |
| ☐ | Keep my bedroom cool |
| ☐ | Keep my bedroom quiet |
| ☐ | Get sunshine in the morning |
| ☐ | Charge my devices outside my bedroom |
| ☐ | Use my devices outside my bedroom |
| ☐ | Use my bed only for sleeping |
| ☐ | Stop using devices and watching TV at least one hour before I go to bed |
| ☐ | Avoid caffeine in the afternoon and evening |
| ☐ | Do relaxing non-screen activities before bed such as reading, taking a shower/bath, listening to or playing music |
| ☐<br>☐ | ________________________________<br>________________________________ |

**How did it go?**

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

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| Clinician Use | |
|---|---|
| Items Answered Total:_________________<br>(Add up the number of items answered) | Item Score Total:_____________<br>(Add up the score for each item) |
| Final Score: (Item Score Total:_______ x 8) / (Item Answered Total:________)= | |

*Scoring Example: If 7 of 8 items were answered and the sum of those 7 responses was 30, the final score would be 30 x 8/7=34, after rounding.*

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