

Lamberg Questionnaire for Pediatric Airway and Sleep “LQ-PAS”

A Risk Assessment Tool for Pediatric Airway and Sleep

Patient Name/DOB: _____ Date: _____

	Yes	No	Don't Know
While sleeping, does your child...			
Have trouble breathing or struggle to breath?			
Stop breathing during the night?			
Have “heavy” or loud breathing?			
Snore regularly?			
Snore loudly?			
Snore more than half the time?			
Appear to be a restless sleeper?			
Child kick during sleep?			
Have nightmares?			
Scream in their sleep?			
Grind their teeth during sleep?			
Sleepwalk?			
Occasionally wet the bed?			
Upon awakening, does your child...			
Have a dry mouth in the morning?			
Tend to breathe through the mouth during the day?			
Wake up feeling un-refreshed in the morning?			
Have a problem with sleepiness during the day?			
Have trouble getting going in the morning?			
Wake up with headaches in the morning?			
We have noticed that our child...			
Does not seem to listen when spoken to directly			
Has difficulty organizing tasks			
Is easily distracted by extraneous stimuli			
Fidgets with hands or feet or squirms in seat			
Interrupts or intrudes on others (e.g. butts into conversations or games)			
Has a teacher or other supervisor comment that your child appears sleepy during the day			
Has been diagnosed with ADD or ADHD			
Additionally...			
Did your child stop growing at a normal rate at any time since birth?			
Is your child overweight?			
Does your child’s teeth seem crooked or misaligned?			
Does your child have allergies?			
Does your child have frequent colds?			
Does your child have difficulty with pronunciation?			

“ARFs” (Airway Red Flags)

For Physicians Use Only
(Check all that apply)

Signs		Symptoms
<input type="checkbox"/> Lips apart at rest (open mouth posture)	<input type="checkbox"/> Speech problems	<input type="checkbox"/> Difficulties breastfeeding
<input type="checkbox"/> Mouth breathing	<input type="checkbox"/> Poor eating and swallowing	<input type="checkbox"/> Dysphagia
<input type="checkbox"/> Lip Incompetence	<input type="checkbox"/> Parafunctional habits	<input type="checkbox"/> Snoring
<input type="checkbox"/> Lip strain when lips together	<input type="checkbox"/> Lower jaw set further back than upper jaw (overbite)	<input type="checkbox"/> Tooth grinding
<input type="checkbox"/> Swollen adenoids and tonsils	<input type="checkbox"/> Eye shiners (dark circles under the eyes)	<input type="checkbox"/> Coughs, Colds, and Chest infections
<input type="checkbox"/> Forward Tongue Resting Posture	<input type="checkbox"/> Bags under eyes	<input type="checkbox"/> Chronic allergies
<input type="checkbox"/> Tethered Oral Tissues	<input type="checkbox"/> Scalloped tongue	<input type="checkbox"/> Nasal Congestion
<input type="checkbox"/> Restricted Lingual Frenulum	<input type="checkbox"/> Arrested growth	<input type="checkbox"/> Snoring and fatigue
<input type="checkbox"/> High Narrow Palate	<input type="checkbox"/> Poor Facial Symmetry	<input type="checkbox"/> Asthma symptoms
<input type="checkbox"/> Crusty and dry lips or mouth	<input type="checkbox"/> Narrow Posterior Airway Space (on ceph or CBCT)	<input type="checkbox"/> Cognitive communication deficits
<input type="checkbox"/> Narrow smile	<input type="checkbox"/> Nasal Resistance (CBCT)	<input type="checkbox"/> Poor academic performance
<input type="checkbox"/> Long Face Height	<input type="checkbox"/> Vertical Position of the Hyoid (should be C4, lower not good) Ceph or CBCT	<input type="checkbox"/> Language delays
<input type="checkbox"/> Flattened Cheeks	<input type="checkbox"/> Increased BMI	<input type="checkbox"/> Frequent headaches
<input type="checkbox"/> Maxilla retruded	<input type="checkbox"/> Under the growth curve	<input type="checkbox"/> Frequent nightmares
<input type="checkbox"/> Weak Chin (lower jaw retruded)	<input type="checkbox"/> Other _____	<input type="checkbox"/> Nocturia
<input type="checkbox"/> Crowded/Crooked teeth		<input type="checkbox"/> Child behavioral disorders
<input type="checkbox"/> Crossbite or open bite		<input type="checkbox"/> Aggressive behavior
<input type="checkbox"/> Malocclusions		<input type="checkbox"/> Irritability
<input type="checkbox"/> Excessively worn teeth		<input type="checkbox"/> Possible dx of ADD or ADHD
<input type="checkbox"/> Gummy Smile		<input type="checkbox"/> Restless Sleep
<input type="checkbox"/> Chronic Otitis		<input type="checkbox"/> Eczema

Pediatric Airway and Sleep Referral

Date: _____

Patient Name/DOB: _____

Physician: _____

Address: _____

Physician Phone: _____

Phone: _____

Physician Fax: _____

Specialty Evaluation Requested by: ENT, Allergist, Oral Surgeon, Orthodontist, Myofunctional Therapist, Speech/Language Therapist, Neurologist, Dietician, Pediatric Dentist, General Dentist, Psychologist, Sleep Specialist including (Initial consultation, Polysomnogram as necessary, and follow-up)

Overnight Attended Sleep Study/Polysomnogram

Reason for referral: _____

Medical History and Pertinent Physical Exam Findings: _____
