Sleep Problems and Gastrointestinal Symptoms in ASD

Participant Information Sheet

The aim of the study is to examine sleep problems and gastrointestinal symptoms in children and adolescents with autism spectrum disorder (ASD) between the ages of 3 to 17 years. We are interested in understanding the relationship between sleep problems and gastrointestinal symptoms, behavior problems, and quality of life. We are also interested in understanding how sleep problems and gastrointestinal symptoms affect both child and parent. Even if your child does not have sleep problems or gastrointestinal symptoms, you are still invited to take part as your information can tell us a lot about why these symptoms present in some children and not in others. If you wish to participate in this study, you are asked to complete the following questionnaire online.

I will be expected to present all related information to my academic supervisor, Dr. Geraldine Leader. We aim to publish this research in an academic journal. Should you agree to have your child participate, I can send you the article when it is published. You or your child will not be identified in any publication. Your child's identity will be kept completely confidential, and will not be shared with anyone else.

Thank you for participating in this research.

If you have any questions about this research, my contact details are below.

Contact Information:

Arlene Mannion

PhD Candidate
Irish Centre for Autism and Neurodevelopmental Research (ICAN),
School of Psychology,
National University of Ireland, Galway.
Telephone: 00353 85 1338720
Email: a.mannion3@nuigalway.ie

Supervisor:
Dr. Geraldine Leader,
Irish Centre for Autism and Neurodevelopmental Research (ICAN),
School of Psychology,
National University of Ireland, Galway.

Email: geraldine.leader@nuigalway.ie

Sleep Problems and Gastrointestinal Symptoms in ASD

* Required

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What is your child's date of birth? *

◆ Gender of your child: *

- ○ Male
- ○ Female

◆ Does your child have an independent diagnosis of autism spectrum disorder? *

- ○ Yes
- ○ No

If Yes, what is their total ADOS (Autism Diagnostic Observation Schedule)

Or ADI-R (Autism Diagnostic Interview-Revised (ADI-R) Score?

- ○ If unsure of score, please click box

◆ What age was your child when they were diagnosed with autism spectrum disorder? *

◆ Does your child have a diagnosis of epilepsy at present? *

- ○ Yes
- ○ No

If Yes, did your child have a seizure before they were diagnosed with autism spectrum disorder?

- Yes
- No

◆ Did your child present with gastrointestinal symptoms (e.g. diarrhea, constipation, abdominal pain, bloating, nausea) before they were diagnosed with autism spectrum disorder? *

- Yes
- No

If Yes, please indicate type of symptoms.

- Diarrhea
- Constipation
- Abdominal pain
- Bloating
- Nausea
- Other

If Other, please enter in the box below.

◆ Does your child have an intellectual disability? *

- Yes
- No

	Mild	Moderate	Severe
If Yes, please state the level of intellectual disability:			

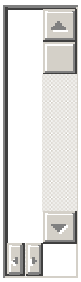
Does your child experience migraines? *

- Yes
- No
- Unsure

◆ What educational intervention is your child currently receiving? *

- ☐ Applied Behaviour Analysis (ABA)
- ☐ Eclectic
- ☐ Other

If other please specify



◆ How many hours per week are they receiving?

: :

◆ Is your child on any type of medication at present? *

- ○ Yes
- ○ No

If Yes, please specify the name of the medication:

What symptoms/condition is this medication used to treat?

◆ Is your child taking melatonin at present? *

- ○ Yes
- ○ No

◆ Please tick if your child has been diagnosed with any of the below co-occurring disorders at present:

- ☐ Attention deficit/hyperactivity disorder (AD/HD)
- ☐ An anxiety disorder

If so, please state type of anxiety disorder:

Does your child have any other medical or psychological disorders? If so, please list

Please enter your email address so I can keep you informed of the results of the study. *

All information will be kept confidential and not shared with anyone.

Please select your country of residence

If your country is not available please enter it in the text box below