**Ambulatory Sleep Device Usability Questionnaire**

What time was the device turned on? ________ What time was the device turned off? ________

1. How easy was it to operate the device?
   
   Easy 1 2 3 4 5 6 7 8 9 10 Difficult

2. How easily did your child wear the device?

   Easy 1 2 3 4 5 6 7 8 9 10 Difficult

3. Did you need to frequently readjust the device?

   Not at all 1 2 3 4 5 6 7 8 9 10 Many times

4. How quickly did your child fall asleep compared to other nights?

   Quickly 1 2 3 4 5 6 7 8 9 10 Long time

5. Did wearing the device have an impact on your child’s sleep and/or ability to fall asleep?

   Positive impact 1 2 3 4 5 6 7 8 9 10 Negative impact

6. If this device became clinically available, would you be willing to have your child wear this device again?

   No 1 2 3 4 5 6 7 8 9 10 Definitely

7. Did you use the instruction manual:

   1 Yes 2 No

   If yes, was the instruction manual helpful?

   Not helpful 1 2 3 4 5 6 7 8 9 10 Very helpful

8. How difficult was the device to place on your child?

   Easy 1 2 3 4 5 6 7 8 9 10 Difficult

9. Were the instructions clear and straightforward?

   Easy 1 2 3 4 5 6 7 8 9 10 Difficult
10. Would you recommend using this device to another parent?

1 Yes 2 No

Additional Comments:
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