SLEEP STUDY PATIENT INSTRUCTION SHEET

AN OVERNIGHT SLEEP STUDY HAS BEEN SCHEDULED FOR_____-

ON _____. YOU SHOULD REPORT TO THE SLEEP CENTER OFFICE AT _____.

THE ADDRESS IS 2810 W. WATERS AVENUE, TAMPA. THE PHONE NUMBER IS 813-935-5501.

WHILE WE WILL MAKE EVERY EFFORT TO CONTACT YOU TO CONFIRM YOU SLEEP STUDY DATE AND TIME, YOU SHOULD CALL THE OFFICE AT 813-935-5501 AT LEAST 24 HOURS BEFORE YOUR SLEEP STUDY IF YOU WILL BE LATE OF IF YOU MUST CANCEL YOUR APPOINTMENT. ***IF YOU MISS YOUR APPOINTMENT OR FAIL TO CANCEL WITHOUT 24 HOURS NOTICE, YOU WILL BE CHARGED A $100 CANCELLATION FEE, WHICH WILL NOT BE COVERED BY YOUR INSURANCE.***

_____***BY INITIALLING I UNDERSTAND THE CANCELLATION/NO-SHOW FEE POLICY.***

WE WILL CONTACT YOUR INSURANCE COMPANY TO PREAUTHORIZE YOUR SLEEP STUDY. WE URGE YOU TO ALSO CALL YOUR INSURANCE COMPANY TO VERIFY THAT YOUR SLEEP STUDY HAS BEEN PREAUTHORIZED. IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING INSURANCE OR BILLING, OR IF YOU NEED TO MAKE FINANCIAL ARRANGEMENTS, PLEASE CONTACT THE OFFICE.

YOUR SAFETY IS IMPORTANT TO US. IF YOU ARE EXPERIENCING ANY SLEEPINESS AS A RESULT OF YOUR SLEEP PROBLEMS, PLEASE HAVE SOMEONE DRIVE YOU TO AND FROM YOUR TEST; HOWEVER, GUESTS ARE NOT PERMITTED TO SPEND THE NIGHT EXCEPT IN SPECIAL CIRCUMSTANCES WHICH HAVE BEEN APPROVED BY THE DOCTOR.

****

WHEN YOU ARRIVE FOR YOUR STUDY YOU WILL BE SHOWN A SHORT VIDEO, AND YOU WILL BE SHOWN ALL OF THE EQUIPMENT AND TESTING MATERIALS THAT WILL BE USED. ANY QUESTIONS WILL BE ANSWERED BY THE TECHNICIANS. TESTING ELECTRODES AND EQUIPMENT WILL THEN BE SET UP, AND YOU WILL BE ALLOWED TO RELAX PRIOR TO BEDTIME.

TESTING BEGINS AROUND 11:00 PM. THE TELEVISION AND ALL ELECTRONICS, INCLUDING CELL PHONES, MUST BE TURNED OFF AT THIS TIME.

YOU WILL BE READY TO BE DISCHARGED BY 6:00 AM THE NEXT MORNING.

ON THE DAY OF THE STUDY, PLEASE FOLLOW THESE INSTRUCTIONS

1. DO NOT TAKE ANY NAPS OF THE DAY OF YOUR STUDY.
2. DO NOT EAT OR DRINK ANY PRODUCTS CONTAINING CAFFEINE (COFFEE, TEA, CHOCOLATE)
3. EAT A REGULAR DINNER PRIOR TO COMING TO THE SLEEP LAB. YOU MAY BRING YOUR OWN SNACKS AND BEVERAGES (WITHOUT CAFFEINE) IF YOU WISH, BUT THE SLEEP LAB DOES NOT PROVIDE ANY FOOD.
4. TAKE YOUR MEDICATIONS AS YOU USUALLY DO, UNLESS THE DOCTOR HAS TOLD YOU OTHERWISE. MAKE SURE THAT YOU BRING YOUR MEDICATIONS WITH YOU, AS **THE SLEEP LAB DOES NOT PROVIDE ANY MEDICATIONS.**
5. DO NOT BRING ANY VALUABLES TO THE SLEEP LAB, INCLUDING LAPTOP COMPUTERS. **THE SLEEP LAB DOES NOT HAVE WI-FI CAPABILITY.**
6. YOUR HAIR AND SKIN SHOULD BE CLEAN AND DRY. PLEASE DO NOT USE ANY MOISTURIZERS OR OILS ON YOUR SKIN. PLEASE DO NOT USE ANY STYLING PRODUCTS (MOUSSE, GEL) IN YOUR HAIR.
7. DO NOT DRINK ANY ALCOHOL PRIOR TO YOUR SLEEP STUDY. NO ALCOHOL IS ALLOWED IN THE SLEEP CENTER.
8. INFORM THE TECHNICIAN IF YOU USE SUPPLEMENTAL OXYGEN. THE SLEEP LAB HAS OXYGEN CONCENTRATORS, IF NEEDED.

YOU SHOULD BRING THE FOLLOWING WITH YOU:

- LOOSE-FITTING CLOTHING TO SLEEP IN. DO NOT BRING SLEEP CLOTHES MADE OF SILK OR SLIPPERY FABRIC. LOOSE-FITTING GYM SHORTS AND TEE SHIRTS WORK BEST.
- ANY MEDICATIONS THAT YOU NEED (WE DO NOT PROVIDE ANY MEDICATION)
- PILLOWS (WE PROVIDE PILLOWS BUT YOU MAY BRING YOUR OWN IF YOU WISH)
- TOILETRIES (TOOTHBRUSH, TOOTHPASTE, ETC.)
- ANY PAPERWORK THAT YOU WERE GIVEN BY THE DOCTOR
- A LIST OF YOUR CURRENT MEDICATIONS
- IF YOU ARE ALSO HAVING A DAYTIME (MSLT) STUDY, YOU MAY ALSO BRING YOUR LUNCH FOR THE NEXT DAY. WE WILL PROVIDE BREAKFAST TO YOU.

****

YOU SHOULD MAKE AN APPOINTMENT TO RECEIVE THE RESULTS OF YOUR SLEEP STUDY IN APPROXIMATELY 2 WEEKS. THIS APPOINTMENT SHOULD BE SCHEDULED WITH YOUR PRIMARY CARE PROVIDER IF YOU HAVE BEEN DIRECTLY REFERRED TO THE SLEEP STUDY BUT HAVE NOT SEEN ONE OF OUR DOCTORS.

WE ARE PLEASED TO SERVE YOU AND IF YOU SHOULD HAVE ANY QUESTIONS OR CONCERNS, PLEASE CALL THE SLEEP LAB MANAGER AT 813-935-5501, EXT. 211.

SLEEP QUESTIONNAIRE

PATIENT INFORMATION

NAME_____DATE_____

DATE OF BIRTH_____SEX_____RACE_____

HEIGHT_____WEIGHT_____NECK SIZE_____

FAMILY DOCTOR_____REFERRING DOCTOR_____

IF YOUR DOCTOR DID NOT SEND YOU TO US, HOW DID YOU FIND OUT ABOUT OUR PRACTICE?

SLEEP PROBLEMS (PLEASE CHECK ALL THAT APPLY)

____SNORING ____GASPING/CHOCKING/PAUSES IN BREATHING WHEN YOU SLEEP

____DIFFICULTY FALLING ASLEEP ____DIFFICULTY STAYING ASLEEP

____TIRED/SLEEPY DURING THE DAY ____UNUSUAL BEHAVIOR DURING SLEEP (TALKING/WALKING, KICKING, ETC.

____MORNING HEADACHES _____OTHER_____

PLEASE DESCRIBE YOUR SLEEP-RELATED PROBLEMS_____

GENERAL HABITS

1. DESCRIBE YOUR WORK SCHEDULE._____
2. IF YOU WORK SHIFT WORK, DO YOU KEEP THE SAME SCHEDULE ON OFF DAYS?_____
3. HOW MUCH COFFEE, TEA OR COLA DO YOU DRINK PER DAY?_____
4. DO YOU SMOKE?_____HOW MUCH?_____
5. DO YOU DRINK ALCOHOLIC BEVERAGES?_____HOW MUCH & WHEN?_____
6. DO YOU EXERCISE REGULARLY?_____HOW MUCH AND WHEN?_____

SLEEP HABITS

1. WHAT TIME DO YOU GO TO BED ON WORK DAYS?_____NON-WORK DAYS?_____
2. WHAT TIME DO YOU GET UP ON WORK DAYS?_____NON-WORK DAYS?_____
3. HOW MUCH TIME DO YOU THINK THAT YOU ACTUALLY SLEEP?_____

4. DO YOU TAKE NAPS?_____WHEN & FOR HOW LONG?_____

5. DO YOU FEEL RESTED AFTER TAKING A NAP?_____

6. DO YOU HAVE A BED PARTNER THAT OBSERVES YOUR SLEEP?_____IF SO, WHAT HAVE THEY OBSERVED?_____

7. HOW LONG DOES IT TAKE YOU TO FALL ASLEEP?_____

8. DO YOU TAKE MEDICATION OR ALCOHOL TO HELP YOU SLEEP?_____HOW MUCH AND HOW OFTEN?_____

9. DO YOU EVER HAVE A STONG URGE TO MOVE YOUR LEGS AND/OR FEET?_____

10. IF YOU ANSWERED YES TO QUESTION #8, DOES WALKING OR STRETCHING HELP?_____

11. DO YOU NOTICE ANY OF THE FOLLOWING WHEN TRYING TO FALL ASLEEP?

- ANXIETY, WORRY OR DISTURBING THOUGHTS ____YES ____NO
- DIFFICULTY BREATHING ____YES ____NO
- PAIN ____YES ____NO
- SEEING/HEARING THINGS THAT DO NOT EXIST ____YES ____NO

12. DO YOU EXHIBIT ANY OF THE FOLLOWING:

- SNORING ____YES ____NO
- STOP BREATHING OR GASPING FOR AIR ____YES ____NO
- GRINDING YOUR TEETH ____YES ____NO
- SLEEPWALKING, TALKING, EATING ____YES ____NO
- KICKING OR TWITCHING OF LEGS/FEET ____YES ____NO
- ACTING OUR YOUR DREAMS ____YES ____NO
- WAKING UP IN THE MIDDLE OF NIGHT ____YES ____NO
- GOING TO BATHROOM EXCESSIVELY AT NIGHT ____YES ____NO
- IRRITIBILITY ____YES ____NO
- MEMORY LOSS ____YES ____NO
- DIFFICULTY CONCENTRATING ____YES ____NO
- DRY MOUTH WHEN YOU WAKE UP ____YES ____NO
- NIGHT SWEATS ____YES ____NO
- TOSSING AND TURNING ____YES ____NO

13. HOW DO YOU FEEL WHEN YOU WAKE UP IN THE MORNING?_____

14. HOW OFTEN DOES YOUR SLEEP PROBLEM EFFECT YOUR LIFE?_____

15. HAVE YOU EVER FELT UNABLE TO MOVE FOR A SHORT TIME WHEN YOU WAKE UP?_____

16. WHEN YOU ARE LAUGHING, SURPRISED, OR ANGRY DO YOU FEEL WEAKNESS?_____

HEALTH AND FAMILY HISTORY

1. DOES ANYONE IN YOUR FAMILY HAVE A SLEEP DISORDER (SLEEP APNEA, NARCOLEPSY, RESTLESS LEG SYNDROME/PERIODIC LIMB MOVEMENT DISORDER, INSOMNIA)?_____IF SO, WHO AND WHICH DISORDER DO THEY HAVE?_____

2. HAVE YOU EVER HAD A SIGNIFICANT HEAD INJURY, TIA OR STROKE?_____

3. DID YOU HAVE ANY SLEEP PROBLEMS AS A CHILD?_____IF SO, DESCRIBE_____

4. HAVE YOU FELT DEPRESSED, ANXIOUS OR WORRIED MORE THAN USUAL IN THE PAST MONTH?_____IF SO, DESCRIBE_____

5. PLEASE LIST CURRENT HEALTH PROBLEMS THAT YOU HAVE.

6. PLEASE LIST ANY SURGERIES.

7. WOMEN ONLY – ARE YOU PRE- OR POST-MENOPAUSAL?_____

8. HAVE YOU ALREADY BEEN DIAGNOSED WITH A SLEEP DISORDER?_____ WHEN AND WHERE?_____

9. ARE YOU ON ANY TREATMENT OR THERAPY (INCL. CPAP) NOW?_____IF SO, PLEASE DESCRIBE._____

Epworth Sleepiness Scale

Name: _____

Date: _____

Your age: (Yr) _____ **Your sex**: ❑ Male ❑ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:-

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	**Chance of dozing**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total	

Score:	
0-10	Normal range
10-12	Borderline
12-24	Abnormal