Porter Adventist Hospital
Centura Health

Parker Adventist Hospital
Centura Health

Castle Rock Adventist Hospital
Centura Health

ACCREDITED FACILITY MEMBER

SLEEP STUDY PATIENT CHECKLIST

☐ **Bring all of the following with you on the night of your study:**

- Your health insurance card
- Your driver's license
- This packet of **completed forms**
- A form of payment (if applicable)

☐ **Personal Hygiene**: Please shower and have freshly washed hair prior to arriving for a sleep study. Hair should be DRY. Do not use hair gels, hairspray, lotions or oils on your face or body, as that interferes with the performance of the monitoring equipment.

☐ **Men only:** If you have stubble, please shave the day of your study. If a full beard, trim neckline.

☐ **Do NOT consume caffeinated foods or beverages after 12pm on the day of your study**.

☐ **Avoid napping the day of your sleep study**.

☐ **Bring comfortable sleepwear, preferably two-piece and loose fitting.**

☐ **If you wish, bring your favorite pillow or blanket**. (The lab provides sheets, blankets, pillows and towels)

☐ **Our Parker and Castle Rock locations have showers available. Please ask the tech to awaken you early so you can leave no later than 6:30 a.m. Don't forget to bring your favorite toiletries.**

☐ **Bring any medications you are scheduled to take at night. They need to be in their original bottles.** The patient must be able to self-administer medications. SLEEP STAFF CANNOT ADMINISTER MEDICATION.

☐ **If you have a CPAP or Bi-Level machine please bring your mask.** If you do NOT know your pressure, **please bring your machine** as well so we may write down your current setting.

☐ **You may bring reading material, needlework, cross-word puzzles, etc**. We have Cable TV and Wi-Fi.

☐ **Please leave jewelry, watches and other valuables at home**.

☐ **Please remember to arrange a follow up visit with your ordering physician two weeks following your sleep study.**

☐ **You will be awakened at approximately 5:30 – 6:00am and allowed to leave by 6:30 AM. You may be awakened earlier if required for work. If someone is picking you up, please have them arrive by 6:30AM.**

What will happen during my study?

Your have been referred to our sleep lab because your physician would like to determine the quality of your sleep and determine if there any irregular breathing patterns or other sleep disorders present.

Once you arrive at the sleep lab you will be greeted by a Registered Sleep Technologist who will run your overnight study and you'll be shown to your room. After the paperwork is completed you will be asked to change into your night clothes and prepare for bed as you normally would.

When you have changed, the technologist will apply multiple adhesive sensors to your body so that data can be collected during the night. Your brain waves, oxygen levels, breathing effort, airflow, heart activity, and muscle movements will all be recorded to help your physician assess your sleep and its impact on your health or quality of life. Most of the sensors will be taped around your face and placed on your scalp. This hook-up process takes about ½ hour. The sensors do not hurt, but in the morning you will need to wash the paste off your skin and out of your hair. Everything is water soluble and will dissolve in a nice warm shower.

All of the sensors connect to a small input box that can be detached and taken with you should you have to get up to the restroom during the night. You may sleep in any position and have plenty of room to change positions.

Typically, you will be in bed by 9:30-10:30 p.m. Please try to attempt sleep as early as possible, even if it is not your typical routine, so we can get the maximum amount of data possible. The Sleep Technologist will be monitoring your study in a separate room all night and will be available to assist you with anything you need.

Depending on the type of information your physician has directed us to gather, you may be awakened halfway through the night to try a therapeutic breathing mask called 'CPAP' for the second half of your study. This is a mask that fits over your nose and attaches to a hose which fits onto a machine by the bedside. Once you become accustomed to it, CPAP prevents snoring and obstructed breathing allowing you to maintain your sleep more effectively.

If we did not try the CPAP, it doesn't necessarily mean that you do not have breathing issues. Some people show low oxygen levels, milder types of sleep apnea, or events very late in the study. A repeat test may be needed if the sleep specialist and your provider feel that it is in your best interest. If you do not tolerate CPAP well, or if CPAP does not completely eliminate events, we may change settings or even add oxygen to show your physician how you did. You can also compare other treatment option to CPAP when you discuss results with your provider. Other options include, surgery on the nose and/or throat, wearing a custom dental mouthpiece, or a combination.

Your study typically ends between 5:30 and 6:00 a.m. at which time you will be unhooked from the equipment, given some paperwork, and then be free to leave no later than 6:30 a.m.

Your Technologist **cannot** discuss sleep study results with you. Results will be sent to your referring provider and you should follow up with them in about 2 weeks.

Once you have seen your provider for results, we are happy to answer any questions you may have. You may also contact our Medical Director Dr. Stephen Duntley for consultation at 303-951-0600

Porter Adventist Hospital
Centura Health

Parker Adventist Hospital
Centura Health

Castle Rock Adventist Hospital
Centura Health

ACCREDITED FACILITY MEMBER

SLEEP QUESTIONNAIRE

Please complete this questionnaire as accurately as possible. This will help identify and treat your sleep concerns.

Name: _____, [ ] M [ ] F Age: _____Date of Birth: _____

Occupation (or former occupation if retired):_____

Referring Provider: _____Primary Care Provider: _____

Weight: _____Height: _____Neck (shirt collar) Size: _____Altitude where you live if known:_____

In your own words... What is your sleep problem? How long has it been a problem? _____

_____

Previous sleep study? [ ] Yes [ ] No, If "YES", Where? _____ When? _____

Have you been previously diagnosed with a sleep problem? (check all that apply)

[ ] Obstructive Sleep Apnea [ ] Restless Legs [ ] Periodic Limb Movements [ ] Other:_____
[ ] Central Sleep Apnea [ ] Narcolepsy [ ] Insomnia [ ] Sleep walking

Are you on Oxygen? [ ] Yes [ ] No, If "YES", _____ Lpm [ ] 24 / 7 [ ] At night [ ] With exertion

Are you using CPAP, Bi-level, ASV, AVAPS or IVAPS during sleep? [ ] Yes [ ] No,

If YES, what are the settings?_____

Which company provided the CPAP machine or Oxygen to you? _____

Have you ever used CPAP in the past but stopped using it? If "YES" why?

_____

Do you have, or tried in the past a custom mouthpiece for snoring or sleep apnea [ ] Yes [ ] No

Please describe your typical sleep schedule	Work / School Days	Weekends / Vacation
Usual bedtime?		
Usual rise time?		
About how long are you in bed each night?		
How many times do you typically awaken?		
How long does it take you to fall back asleep?		

Do you typically,	Yes	No	Do you typically,	Yes	No
Wake up and cannot get back to sleep?	[ ]	[ ]	Watch the clock when trying to fall asleep?	[ ]	[ ]
Unable to fall asleep in 60 minutes or less?	[ ]	[ ]	Use prescribed medication to sleep?	[ ]	[ ]
Drink beer or mixed drinks to help fall asleep?	[ ]	[ ]	Sleep better when travelling or on vacation?	[ ]	[ ]
Sleep propped up or with more than 3 pillows?	[ ]	[ ]	Sleep in a recliner or elevated bed?	[ ]	[ ]
Exercise on a daily basis?	[ ]	[ ]	Exercise within 2 hours of bedtime?	[ ]	[ ]
Smoke or use nicotine products before bed?	[ ]	[ ]	Wake up from sleep to smoke?	[ ]	[ ]
Take daily naps?	[ ]	[ ]	Feel better or refreshed after taking a nap?	[ ]	[ ]
Dream during your naps?	[ ]	[ ]	Use laptop, I-pad, tablet, video game in bed?	[ ]	[ ]

How long are your typical naps?_____

What time of day to you usually take a nap?_____

Patient Label

Porter Adventist Hospital
Centura Health

Parker Adventist Hospital
Centura Health

Castle Rock Adventist Hospital
Centura Health

ACCREDITED FACILITY MEMBER

Sleep Habits

In what position do you usually sleep? (check ALL that apply) [ ]Back [ ] Side [ ] Stomach [ ] Sitting up

Do you do any of the following in bed? (check ALL that apply) [ ] Eat [ ] Read [ ] Watch TV [ ] Smoke

Health Habits

Do you drink coffee or tea? [ ] Yes [ ] No If YES, how much? _____cups per day

Do you drink caffeinated sodas or energy drinks? [ ] Yes [ ] No If YES, how much? _____cans/bottles per day

Do you drink alcohol? [ ] Yes [ ] No If YES, how many servings a day?_____
(serving = can of beer, glass of wine, shot of liquor)

Do you currently use tobacco? [ ] Yes [ ] No If YES, how much?_____

Have you EVER been a smoker? (Cigarettes, cigars, pipe) [ ] Yes [ ] No If YES, when did you last smoke?_____

Please consult someone who has witnessed you sleeping when answering these questions, describe a "typical" night

Sleep Problems, please check appropriate frequency that it happens	Nightly	Weekly	Rarely	Never
Do you snore?				
Can your snoring be heard in another room?				
Do you stop breathing while you sleep?				
Do you wake up gasping?				
Do you have a sore throat when you wake up?				
Do you have a headache when you wake up?				
When awake, seated or lying down, do you have a creepy, crawly sensation in your legs?				
Do these sensations in your legs interfere with falling asleep?				
Do your legs kick, jerk, or twitch while you are sleeping?				
Do you talk in your sleep?				
Do you eat in your sleep?				
Do you walk in your sleep?				
Do you grind your teeth during sleep?				
Do you wake up confused from sleep?				
Do you act out your dreams?				
Have you ever hurt yourself, or someone else due to sleep related behaviors or activity?				
Do you think you have insomnia?				
Do you have a hard time falling asleep?				
Do you have a hard time staying asleep?				
Does strong emotion cause any part of your body to become weak, limp or temporarily unable to move?				
Do you have vivid dream-like images or hallucinations when drowsy, waking up/falling asleep?				
Do you ever have a feeling or being paralyzed or unable to move, even though your mind is awake and your body feels asleep?				
Do you have sudden, irresistible urges to sleep?				
Do you have heartburn or acid reflux (GERD)?				
Do you recall dreaming?				
Do you have bad dreams or nightmares?				
Have you fallen asleep at work or during social events?				
Have you fallen asleep while driving?				
Awaken with chest pain or heaviness in chest?				
Awaken with heart racing?				

Patient Label

ACCREDITED FACILITY MEMBER

Porter Adventist Hospital
Centura Health

Parker Adventist Hospital
Centura Health

Castle Rock Adventist Hospital
Centura Health

Please check any past or present medical conditions (see checkmark examples)

√	CARDIAC - HEART	√	NEUROLOGICAL - BRAIN	√	PSYCHOLOGICAL
	Heart Attack or Coronary Disease		Stroke or frequent TIA's (mini strokes)		Depression
	Congestive Heart Failure (CHF)		Parkinson's		Anxiety
	Peripheral Vascular Disease		Paralysis		PTSD
	Atrial Fibrillation		Neuropathy		Seasonal Affective Disorder
	Pacemaker or ICD		Headaches		Bipolar Depression
	High Blood Pressure		Dementia or Confusion		Schizophrenia
	Other irregular heart beats		Muscle weakness		**EYES, EARS, NOSE, THROAT**
	PULMONARY - BREATHING		Seizures / Epilepsy		Speech problems
	COPD/Emphysema		**OTHER**		Visual problems/Blindness
	Pulmonary Hypertension		Dialysis		Hearing loss
	Asthma		Pre-transplant		Deafness
	Tracheostomy		Post-transplant		Seasonal allergy (hay-fever)
	ENDOCRINE		Chronic Pain		Dizziness or vertigo
	Diabetes (insulin dependent)		Fibromyalgia		Swallowing difficulty
	Type II Diabetes		Lupus		Broken nose in past
	Under-active thyroid (hypothyroidism)		Arthritis		Nasal congestion
	Over-active thyroid (hyperthyroidism)		Cancer		TMJ problems
	Low testosterone (males only)		Polycythemia (thick blood)		Frequent nose bleeds
	INFECTIOUS CONDTIONS		Anemia (low iron)		Vocal cord paralysis
	Recent C. Diff infection				
	MRSA, VRA, or isolation in hospital		**SURGICAL HISTORY**		**SURGICAL HISTORY**
	TB		Nasal surgery		UPPP / Throat surgery for snoring
	HIV		Jaw advancement		Sinus surgery
	Hepatitis		Tonsils & adenoid removal		Lung surgery
	Shingles		Heart bypass or stents		Gastric bypass or wt. loss surgery

FAMILY HISTORY: Does anyone in your family have any of the following? (please say who, and check all that apply)

[ ] Sleep Apnea_____ [ ] Restless Leg Syndrome _____ [ ] Narcolepsy_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, *in contrast to just feeling tired?*
This refers to your usual way of life. Even if you have not done some of these things recently, think how they would have affected you.
Use the following scale to choose *the BEST number* for each situation and circle:

0 = *never doze* 1 = *slight* chance of dozing 2 = *moderate* chance of dozing 3 = *high* chance of dozing

Situation: (Circle the best answer)	**Never**	**Slight**	**Moderate**	**High**
Sitting & reading	*0*	*1*	*2*	*3*
Watching TV	*0*	*1*	*2*	*3*
Sitting inactive in a public place (meeting, movie, etc)	*0*	*1*	*2*	*3*
As a passenger in a car for a hour without a break	*0*	*1*	*2*	*3*
Lying down to rest in the afternoon when circumstances allow it	*0*	*1*	*2*	*3*
Sitting and talking to someone	*0*	*1*	*2*	*3*
Sitting quietly after lunch without alcoholic beverages	*0*	*1*	*2*	*3*
In a car, stopped for a minute in traffic	*0*	*1*	*2*	*3*
Total Score (adding all 1's, 2's and 3's)				

Patient Label

ACCREDITED FACILITY MEMBER

Porter Adventist Hospital
Centura Health

Parker Adventist Hospital
Centura Health

Castle Rock Adventist Hospital
Centura Health

Are you allergic to ANY medications?_____

Are you allergic to [ ] Latex? [ ] Tape? Other:_____

Current Medication List (please list all medications you take, even if occasionally)

Name of Medication	Dose	How many times daily?	Time of last dose?	Reason or condition for which you are taking this medication

Patient Label