Olympia Multi-specialty Clinic

Sleep Center & Neurology
Chike M. Linton, MD
3920 Capital Mall Drive SW Ste 302
Olympia, WA 98502
Phone: 360-236-1451 Fax: 360-236-1450

Sleep Study – Important Information & Instructions

This packet consists of time sensitive material that should be completed prior to your scheduled sleep study. Please bring these completed forms back with you the night of your sleep study.

Common symptoms of sleep disorders are loud snoring, excessive daytime sleepiness, leg jerking, and nighttime restlessness. Because you suffer from one or more of these symptoms and/or other symptoms, your doctor has recommended that you have a sleep study. The following questionnaires have been designed to assist your sleep physician in the diagnosis of your sleep disorder:

- Bed Partner Questionnaire
- Sleep History

The technologists administering the sleep studies at OMC are Board Registered Polysomnographic Technologists. However, because they are not a physician, they are unable to provide information regarding a diagnosis or any other results of your sleep study. The study will be formally evaluated by the Sleep Physician who will provide the results to you.

The technologists are certified in Basic Life Support and are capable of reacting to a life threatening situation; however, they are not nurses and cannot provide nursing care. If you have special needs that require nursing or other specialized care, please arrange to have a family member or caregiver stay with you during your sleep study.

We understand you have choices in where you receive your sleep study and we are pleased that you have chosen OMC Sleep Center for your sleep evaluation. If you have questions, or are in need of more educational material, please do not hesitate to contact our office at (360) 236-1451.

Your Appointment is scheduled on: _____

Please arrive by: _____ PM / AM

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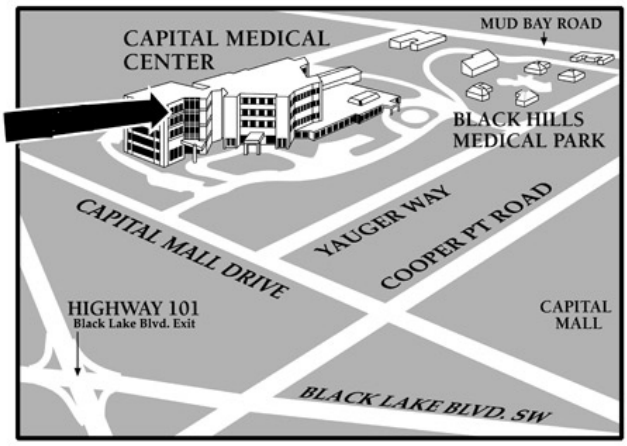
LOCATION

We are located on the third floor of the Physician's Pavilion, next to Capital Medical Center.

- All parking is convenient and free at Capital Medical Center.



DIRECTIONS

From Interstate-5:

- Take exit 104 to merge onto US-101 N
- Take the Black Lake Blvd exit toward W Olympia
- Keep to the right on the exit ramp and turn right onto Black Lake Blvd SW
- Immediately move to the left and turn left onto Cooper Point Rd SW
- In approximately half a mile, turn left onto Capital Mall Dr SW.
- In approximately half a mile, turn into the hospital parking lot on the right

Additional Instructions:

- You should enter through the doors at the Physician's Pavilion (to the left of the hospital main entrance). If the doors are locked (after 8:00 pm) please call:
  - **CMC Security** at **(360) 485-2007** and they will meet you at the doors to let you in.
- If you don't have a phone or cannot get through to Security, please go to the Emergency Room entrance at the back of the hospital and they will contact them to make sure you get to our sleep lab.

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YOUR PROCEDURE

☐ **PSG** - Polysomnogram – attended overnight sleep study that monitors respiratory efforts, oxygen levels, and brain activity.*

- The application of PAP therapy will be initiated during a routine diagnostic PSG if a patient displays severe obstructive sleep apnea & meets the split-night protocol before 2:00 am. Otherwise, a second study with application of PAP therapy will be scheduled.

☐ **PSG w/PAP** - Polysomnogram – attended overnight sleep study with application of positive airway pressure therapy.

☐ **MSLT** - Multiple Sleep Latency Test – an attended nap study that will follow an overnight PSG to test for Narcolepsy and Excessive Sleepiness. The need for an MSLT will not be determined until 5AM the morning following your PSG. Patients staying for an MSLT should plan to be in the sleep center until approximately 1PM. We recommend that patients bring snacks, movies, puzzles, and books to keep occupied.

QUESTIONNAIRE INSTRUCTIONS

NOTE: Please be sure to fill out the personal information required on every questionnaire. Loose papers can be lost, and without a name, we are unable to match the paperwork to the patient.

SLEEP HISTORY: Many questions are repeated or reworded purposefully, please be sure to fill each questionnaire out entirely.

BED PARTNER QUESTIONNAIRE: Many people do not have a bed partner, so a family member or close friend who is capable of observing the patient while sleeping, may fill out this form.

SLEEP LOG (*MSLT only*): The sleep log is an integral part of your sleep evaluation. Your sleep physician will use this to assess how you sleep at home, compared to your sleep at the sleep center. Bathroom trips, water consumption, eating, and long periods of wake should be documented as accurately as possible. There are a total of 14 nights available on the log; however some patients may be seen in the sleep center sooner. We ask that each patient bring in the log even if it is only partially completed.

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PREPARING FOR YOUR SLEEP STUDY

If you have any questions about the sleep study process, please feel free to call us at (360) 236-1451. You may also visit our website at www.omcsleepcenter.com for access to our forms, resources on diagnosis and therapy, and information specific to the services we offer at our clinic. Please also make sure you are familiar with your insurance coverage and any cost-sharing you may have.

Below, you will find a list of recommendations that will help you prepare for your sleep study.

RESTRICTIONS	**WHAT TO BRING**
• Avoid naps, caffeine and alcoholic beverages the day of the study. • Avoid body lotions • Make sure hair is dry **MEDICATIONS** • Bring all medications with you (*Our technologist will not be able to administer or store medication for you)* • Discontinue any medication discussed with the physician as recommended; otherwise your study may be canceled.	• Pillow • Pajamas (*nightgown, boxers, long shirts, or pajama sets are okay – NUDITY is not permitted; lab is kept at an average temperature, so keep that in mind if you sleep "hot" or "cold"*) • Slippers and/or socks • Bathroom Toiletries (*toothbrush, deodorant, etc.)* • Reading Material/DVD/Other (*you may bring a book, magazine, movie, etc.)* • Wi-Fi is available

WHAT TO EXPECT

When you arrive to the sleep center you will be greeted and escorted to your room. The technologist will explain the hook-up process in a step-by-step fashion. The hook-up takes approximately 30-45 minutes (up to an hour with CPAP fitting). A series of calibrations and tests will be conducted after the hook-up is completed to ensure the electrodes are connected appropriately. The technologist will be present throughout the duration of your sleep study. In order to assess our patients visually there will be an infrared camera in each of our testing rooms. An intercom is present in each room, which will allow the patient to communicate with the technologist and the technologist to communicate with the patient.

The technologist will wake you up between 5:00 – 6:00 AM to start the un-hook process. There will be a post-sleep questionnaire and a survey to fill out prior to leaving. The quality of your sleep may differ from usual, so you may not feel completely rested. Because of this, we recommend that you arrange for someone to drive you to and from your sleep study, but it is NOT required.

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Sleep Study Patient Commitment

I have discussed the necessity of sleep testing on myself with the Sleep Physician and have decided to schedule an appointment time for the study.

I understand that if I fail to keep this appointment or fail to cancel/reschedule at least 48-hours prior to my appointment, I will be responsible for a **$100 fee**. I also understand my insurance cannot be billed for this fee.

Signed: _____ Date: _____

Print Name: _____

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BED PARTNER QUESTIONNAIRE

Patient: _____ Date: _____

Please check any of the behaviors that you have observed the patient doing while asleep:

- ☐ Loud snoring
- ☐ Light snoring
- ☐ Pause in breath
- ☐ Sleep talking
- ☐ Sleep walking
- ☐ Biting tongue
- ☐ Kicking with legs
- ☐ Grinding teeth
- ☐ Head rocking/banging
- ☐ Bed-wetting
- ☐ Becoming rigid and/or shaking
- ☐ Twitching of legs or feet
- ☐ Sitting up in bed (but not awake)
- ☐ Getting out bed (but not awake)

How long have you been aware of the sleep behavior(s) that you checked above?
Describe the behavior checked above in more detail. Include a description of the activity, the time it occurs, and the frequency in which it occurs:
If you have observed snoring, do you remember pauses in the snoring or occasional loud snorts?

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Patient: _____ DOB: _____

SLEEP HISTORY INFORMATION		
Have you had an overnight pulse oximetry before? □ Yes □ No	If Yes, When:	Results:
Have you had an overnight sleep study before? □ Yes □ No	If Yes, When:	Results:
Have you ever used continuous positive airway pressure (CPAP)? □ Yes □ No		Results:
Do you use CPAP or BiPAP at home now? □ Yes □ No		
How do you feel since using CPAP or Bi-Level therapy? □ Better □ Worse □ Same □ Other (*Please Explain Below*)		
Do you use supplemental oxygen at home? □ Yes □ No	When: □ Day □ Night □ Both	Level:

Have you ever experienced any of the following health problems?

□ Low Thyroid	□ Hiatal Hernia	□ Polycythemia	□ Broken Jaw
□ Gastric Reflux	□ Changed Voice	□ Epilepsy	□ Adenoid Removal
□ Brain Infection/Tumor	□ Tonsillectomy	□ Nose Surgery	□ Stroke
□ Heart Attack	□ Sinus Surgery	□ Recent Weight Gain	□ Lung Disease

INSTRUCTIONS: Select the number that applies to you best. Response to these questions should be based on symptoms present in the last year. Many questions are worded similarly, your response to every question is important.

POSSIBLE RESPONSES:

0 = Never **1** = Sometimes **2** = Often
3 = Always or Almost Always **4** = In the past, not currently **5** = Doesn't Apply

□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have difficulty sleeping?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do thoughts race through your mind and prevent you from sleeping?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you feel afraid to go to sleep?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you wake up during the night and have trouble getting back to sleep?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you worry about things and have trouble relaxing?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you wake up earlier than you would like?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you lie awake for half hour or more before falling to sleep?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you feel sad and depressed?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Have you been told that you snore?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Have you been told that you stop breathing while you're sleeping?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have high blood pressure?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Have your friends and family said they've noticed changes in your personality?

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□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Have you gained weight?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you sweat excessively at night?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Have you noticed your heart pounding or beating irregularly during the night?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you wake-up in the morning with a headache?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have trouble sleeping when you have a cold or congestion?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you suddenly wake up gasping for breath during the night?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Are you overweight?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you seem to be losing your sex drive?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you feel sleepy during the day?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have trouble concentrating at school or work?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	When you're angry or surprised do you lose muscle control or feel limp?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Have you fallen asleep while driving?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you feel like you are in a daze?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Have you experienced vivid, dreamlike scenes upon falling asleep or awakening?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Have you fallen asleep during physical effort?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you feel like you are hallucinating when you fall asleep?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you feel like you have to work around the clock to get everything done?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Have you fallen asleep while laughing or crying?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have trouble at work due to sleepiness?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have vivid nightmares soon after falling to sleep?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you fall asleep during the day?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you fall asleep regardless of your efforts to stay awake?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you feel unable to move upon awakening?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you wake up with heart burn?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have a chronic cough?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have to use antacids on a weekly basis?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have morning hoarseness?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you wake up at night coughing or wheezing?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have frequent sore throats?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Other than when exercising, do you experience muscle tension in your legs?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Have you (or others) noticed that parts of your body jerk (while awake or asleep)?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Have you been told that you kick at night?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you experience aching or crawling sensations in your legs?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you experience leg pain during the night?

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□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Does it seem as if you cannot keep your legs still at night?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you awaken with sore or achy muscles?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Even though you slept through the night, do you feel sleep during the day?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you suddenly wake gasping for breath during the night?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have an abnormal sleep schedule?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Does your sleep on the weekends differ from the weekdays?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Does pain or discomfort disturb your sleep?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you drink alcohol in the evening?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you drink caffeinated beverages in the evening?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you use medication to help you sleep?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you use medication to help you stay awake?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Has anyone who has observed you sleep told you that your sleep is abnormal?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	When overcome with daytime sleepiness do you feel refreshed after a nap?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have depressed feelings?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have swelling in your feet or hands?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have sinus problems?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have shortness of breath?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you experience memory loss?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have nightmares?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you have difficulty swallowing?
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5	Do you smoke?

WEEKDAY SLEEP:	
What is your normal bedtime during the week?	What time do you wake up?
During the time you're in bed how many hours of actual sleep do you think you get?	
WEEKEND SLEEP:	
What is your normal bedtime during the weekend?	What time do you wake up?
During the time you're in bed how many hours of actual sleep do you think you get?	
WORK:	
What type of work do you do?	Are you a shift-worker? □ Yes □ No
How often do you change/rotate shifts?	How long on current shift?
Current Shift Hours: Start: _____ am / pm End : _____ am / pm	