BBGH
BOX BUTTE GENERAL HOSPITAL

PT ID #:_____

SLEEP STUDY INSTRUCTIONS

PATIENT NAME: _____

Your nighttime sleep study is scheduled for: _____

It is very important for you to read the following information and complete the questionnaires before coming to the Sleep Lab.

THINGS TO REMEMBER

- Day of study, **do not** take a nap, try to keep busy.
- Day of study, please limit your caffeine intake, also **no** consumption of caffeine products after 12 noon (coffee, sodas and chocolate).
- Arrive at Box Butte General Hospital, Medical Arts Plaza Building, at _____p.m. Please enter thru the Medical Arts Plaza entrance which is south of the Main Hospital entrance located under the large awning.
- Please shower, wash your hair and refrain from using any hair care products. If you normally shave then please do so the day of your test.
- Please be aware that during your study you will not be allowed to have the following with you in your room: pagers, personal phones or watches as they interfere with the test results. If a phone or pager must be brought in with you, then the technician in charge of your testing will be more than happy to keep it in the observation room in case of emergencies.

PLEASE BRING WITH YOU

- **Toiletry items**: Combs/hair brush, toothbrush/toothpaste, shampoo, and shaving kit.
- **Clothes**: Loose fitting nightclothes and a change of clothes for the next day.
- **Medications**: Any medication that is prescribed by your doctor, or over the counter medications you are currently taking (in their original containers) and a current list of your medications.

******No Medication will be Administered by our Staff******

- **Diabetic Supplies:** Please bring your glucometer and supplies.
- **Reading Material**: Something to help relax in your room before your test.
- **Questionnaire:** Please bring the completed questionnaire previously sent to you.

If you become sick or cannot make your scheduled appointment, please call the hospital at 308-762-4357 ext 3342 or ext 3489 as soon as possible so another patient can be scheduled.

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PATIENT SLEEP STUDY INFORMATION

What is a Polysomnogram?

A Polysomnogram is a procedure that reads and registers body functions during sleep. Some of these measurements include:

- **Brain waves** [Electrodes placed on patient's scalp]
- **Heart beats**
- **Eye Movements** [Electrodes placed by the patient's eyes]
- **Leg movements** [Electrodes placed on the patient's legs]
- **Airflow Breathing** [Sensor placed under the patient's nose]
- **Chest/Abdominal Breathing** [Sensors placed on the patient's chest and abdomen]
- **Blood Oxygen Levels** [Sensor attached to the patient's finger]

Why Record This Information?

During sleep, the body functions differently than while awake. Recording these readings will help the doctors better diagnose and treat your sleep problem.

How Can I Sleep With All Of These Things On Me?

Surprisingly, most people sleep reasonably well. The sensors are applied so that you can turn and move during sleep. Our staff will try to make your environment as comfortable as possible.

Will The Sensor Devices Hurt?

No. Although sometimes in rubbing the skin or putting on the electrodes there will be mild and temporary discomfort and skin irritations.

Will I Be Given A Drug To Help Me Sleep?

No, unless these have been prescribed by your doctor. ***PLEASE, DO NOT STOP ANY OF YOUR MEDICATIONS WITHOUT FIRST CONSULTING YOUR PERSONAL PHYSICIAN!***

What Should I Bring?

Your own pillow, bed clothes [Preferably two piece pajamas or gym shorts and T-shirt], and a book or something to work on while waiting. **Bring Your Prescribed Medications!**

What Happens To The Polysomnogram?

Sleep studies are reviewed the following day by Mark Schultz, RPSGT and forwarded to Dr. Norman Imes in Oklahoma City, an expert in the field of sleep medicine. Generally it takes less than 5 days for the study to be scored and a medical report to be returned to your doctor. Your primary care physician will contact you for a follow up visit to review your results with you.

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INSTRUCTIONS FOR COMPLETING QUESTIONAIRES

While an extensive sleep history will be taken by the Sleep Technician the night of your study, answering these questionnaires will aid in the diagnostic process. Enclosed are the following questionnaires:

1. MEDICATIONS LIST
   - It is IMPORTANT that you provide the Sleep Technician with a complete list of your current medications with the dosage and daily intake clearly stated.
2. SLEEP LOG/SLEEP HISTORY
   - Please begin this as soon as you receive the questionnaire packet.
3. QUESTIONS ABOUT YOUR SLEEP AND WAKE BEHAVIOR
   - please be as thorough as possible
4. BED PARTNER QUESTIONNAIRES
   - If you have a bed partner who has recently observed your sleep please have them complete this questionnaire.
5. EPWORTH SLEEPINESS SCALE
   - This is a standard medical assessment that is scored by the registered sleep technologist and aids in your diagnosis.

PLEASE BRING THESE COMPLETED QUESTIONNAIRES WITH YOU TO THE SLEEP LAB FOR EVALUATION THE NIGHT OF YOUR STUDY

Revised 6-01-10

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PT ID #:_____

EPWORTH SLEEPINESS SCALE

NAME: _____

DATE: _____ AGE: _____

GENDER: (circle one) MALE FEMALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not 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 off
1- slight chance of dozing
2- moderate chance of dozing
3- high chance of dozing

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g., a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour Without a break	0	1	2	3
Lying down to rest in the afternoon When permitted	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch with no alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

TOTAL SCORE: _____ AVG. AMOUNT(HOURS) OF SLEEP PER NIGHT _____

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PATIENT INFORMATION

PATIENTS NAME: _____
First Middle Last

ADDRESS:_____

CITY: _____ STATE: _____ POSTAL CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____/ _____/ _____ SOCIAL SECURITY NUMBER: _____-_____-_____

AGE: _____ HEIGHT: _____ WEIGHT: _____ SEX: FEMALE MALE

MARITAL STATUS (Please Circle One) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: *(Please Circle One)* SELF SPOUSE CHILD OTHER

PRIMARY CARE PHYSICIAN:_____ REFERRED BY: _____

PATIENT'S EMPLOYER INFORMATION: COMPANY: _____

EMERGENCY CONTACT: _____ Ph. #:_____ WORK PHONE: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESONSIBLE PARTY NAME: _____
If Same as Above Please Write **Same** First Middle Last

ADDRESS: _____

CITY: _____ STATE: _____ POSTAL CODE: _____ SEX: FEMALE MALE

DATE OF BIRTH: _____/ _____/ _____ SOCIAL SECURITY NUMBER: _____-_____-_____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

RESPONSIBLE PARTY'S EMPLOYER: _____ WORK PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: _____

GROUP NAME: _____ GROUP NUMBER:_____ CONTRACT (ID) NUMER: _____

SUBSCRIBERS NAME: _____ SUBSCRIBER DATE OF BIRTH _____/ _____/ _____

PATIENT RELATIONSHIP TO SUBSCRIBER: *Please Circle One* SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE COMPANY/ MEDICARE SUPPLEMENT: _____

ADDRESS: _____ PHONE: _____

GROUP NAME: _____ GROUP NUMBER:_____ CONTRACT (ID) NUMER: _____

SUBSCRIBERS NAME: _____ SUBSCRIBER DATE OF BIRTH _____/ _____/ _____

PATIENT RELATIONSHIP TO SUBSCRIBER: *Please Circle One* SELF SPOUSE CHILD OTHER

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SLEEP QUESTIONNAIRE

PATIENTS NAME: _____ SOCIAL SECURITY NUMBER:_____

DOB: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

WHAT PROBLEMS DO YOU HAVE WITH SLEEP?

PLEASE CHECK ALL THAT APPLY

Loud snoring	Tired/sleepy during the day	Sleep talking
Toss and turn in bed	Difficulty falling asleep	Sleep walking
Frequent awakenings	Legs movement at night	Act out dreams
Shallow breathing at night	Legs uncomfortable at night	Teeth grinding
Stop breathing during sleep	Muscle cramps at night	Bed-wetting

CIRCLE LEVEL OF SNORING: 0 1 2 3 4 5 6 7 8 9 10

Circle position(s) of sleep snoring is heard: Left side Right side Back Stomach

How many years has snoring occurred? _____ Worsened over how long? _____
How many nights a week, on average, are you disturbed by poor sleep? _____

Has snoring caused you or bed partner to move to another room? YES / NO
Has your own snoring awakened you from sleep? YES / NO
Have you had any facial injury or a broken nose? YES / NO
Have you undergone any nose or throat surgery, including tonsillectomy? YES / NO
Do you awaken with a headache? YES / NO
Has anyone noticed periods where you stop breathing at night? YES / NO

SLEEP HABITS

What time do you usually get into bed at night? _____
How long does it take you to fall asleep? _____
How many times do you awaken at night? _____ Why?_____
What time do you get up in the morning? _____
Do you feel refreshed or still tired? Comments: _____
Rate your level of energy during the day. (poor) 0 1 2 3 4 5 6 7 8 9 10 (excellent)
Do you take naps? YES / NO
Do you feel refreshed after a nap? YES / NO
Do you ever doze or nod off if you sit for awhile? YES / NO
Are you a shift worker? YES/NO If so, what shift? _____

LEG MOVEMENT

I have an aching or crawling sensation in my legs in the evening. YES / NO
I cannot keep my legs still in the evening YES / NO
I have an unpleasant sensation in my legs that improves with activity and gets worse with rest or inactivity. YES / NO

OTHER QUESTIONS

How much caffeine do you consume during each day? _____ Coffee: _____ Cola/tea/etc. _____
Do you drink alcohol before bedtime? (kind and number of drinks) _____
Sudden weakness with strong emotion (anger or laughter) YES / NO
Indigestion / heartburn during sleep? YES / NO
Paralysis on waking or falling asleep? YES / NO
Hallucination on waking or falling asleep? YES / No

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GENERAL HEALTH QUESTIONS

Previous and Current Medical Problems and Illnesses

YEAR	ILLNESS OR MEDICAL PROBLEM	HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Surgeries

YEAR	ILLNESS OR MEDICAL PROBLEM	HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: to medications, plants, foods, dust molds, etc.

Medication/allergen	Reaction	Medication/allergen	Reaction
1) _____	_____	3) _____	_____
2) _____	_____	4)_____	_____

Medications

Please list all medications, vitamins, herbal supplements you are currently taking

MEDICATION: DOSAGE: # PER DAY_ REASON FOR TAKING:_____

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____

Have you ever used "recreational" drugs? YES / NO

IF YES PLEASE CIRCLE: LSD COCAINE AMPHETAMINES MARIJAUNA / HASHISH INHALENTS / AEROSOLS *OTHER*

Personal Habits

Tobacco Do you currently smoke or chew? Yes / No Amount per day _____

Travel Miles traveled daily to work, during, work, or for recreation._____

Diet: Special diet or eating habits: _____

Do You Exercise? Walk_____ Aerobic_____ Other _____ No_____

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BED PARTNER QUESTIONNAIRE

NAME OF PATIENT:_____ DATE:_____

NAME OF PERSON FILLING OUT FORM:_____

I HAVE OBSERVED THIS PERSON SLEEP:

ONCE OR TWICE FREQUENTLY EVERY NIGHT

PLEASE CHECK ANY OF THE FOLLOWING BEHAVIORS OBSERVED WHILE THIS PERSON WAS SLEEPING

Light Snoring	Loud snoring	Occasional loud snorts	Choking
Grinding Teeth	Leg Movement	Pauses in Breathing	Crying Out
Awakening in Pain	Becoming ridged	Sitting up in bed not awake	

Other:_____

Please describe any additional comments you have about the sleep disorders above. Might want to include activity, the time during the night in which it happens, frequency during the night, and whether it occurs every night.

Has this person ever fallen asleep during normal daytime activities or in potentially dangerous situations?

Yes No

If yes, please explain:

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SLEEP DIARY

NAME _____

START DATE _____ COMPLETION DATE _____

Please darken the times with pen that you are asleep during the daytime and/or nighttime

Date	Day	6am	7am	8am	9am	10am	11am	noon	1pm	2pm	3pm	4pm	5pm
	1												
	2												
	3												
	4												
	5												
	6												
	7												
	8												
	9												
	10												
	11												
	12												
	13												
	14												

Date	Day	6pm	7pm	8pm	9pm	10pm	11pm	mid-night	1am	2am	3am	4am	5am
	1												
	2												
	3												
	4												
	5												
	6												
	7												
	8												
	9												
	10												
	11												
	12												
	13												
	14												

If sleeping medications were taken, please make note of the medication, and star the date/time that these medications were taken. _____

Revised 06-01-10