PROVIDENCE
Health & Services

Providence Sleep Disorders Centers

Dear Sleep Study Patient:

Thank-you for choosing Providence for your Sleep Study.

Please note: we have several facilities in Oregon, be sure you come to the facility listed here:

Providence Portland Medical Center
4805 NE Glisan St. Suite 3M
Portland, Oregon 97213
Phone: 503-215-3095
See enclosed map

In order to assure a successful test, please read this letter now and again prior to your appointment.

PRIOR TO YOUR SLEEP STUDY:

1. Medications:
    a. Current Medications: Please bring your usual medications you will need during the night and for the next morning. This includes personal medical supplies such as insulin and other diabetic supplies, nebulizers and medication or inhalers if you take them, breast pumps, walker, cane, etc… Due to regulations we are NOT able to provide medications- not even Tylenol for a headache.
    b. Sleep Aide: If you and your physician feel that you will need a sleep aid for the study, obtain the prescription AND fill it prior to arriving at the Sleep Center. While we are located at the hospital, we are an outpatient department and are not allowed to prescribe or dispense any medications or medical supplies.

2. Unusual Sleep Schedule: Call us if you are scheduled for your study during hours when you do not ordinarily sleep. It is very important to keep you as close to your normal sleep schedule as possible.

3. Special Needs: If you have other special needs, please notify us in advance so that we may be better prepared to care of you. This would include people with mobility issues (difficulty getting around, or getting to restroom by yourself), or people with need for interpreter, lift assist devices or commode by the bedside, etc…

4. Claustrophobia: If you are claustrophobic or have panic attacks with masks please contact us several days ahead so that we can arrange for an educational session and trial of masks to better help you tolerate your testing.

5. Sleep Questionnaire: Complete the enclosed questionnaire. This will help our sleep physicians interpret your study more accurately.

6. Cancellation or Reschedule: A technologist is assigned to you for your care during the night. We require 48-hour notice for a cancellation or rescheduling, so we may fill your spot with another person for our tech to care for that night. You may call the scheduling secretary during normal business hours. After normal business hours or on weekends, call and leave a message for the staff.

7. Sleep Routine: To make sure your testing is accurate; please keep to your normal sleep routine prior to testing. *However, the day of your study please avoid sleeping in late that day, do not nap and avoid excessive caffeine.* If you must nap, please do so before noon and for no more than 30 minutes.

8. Future Reference: There are many steps involved in your sleep testing and people have many questions now and later. This packet should provide you with answers to most common questions that you may have. Please read the entire packet and keep for your reference and keep all materials provided until your process is completed.

NIGHT OF THE STUDY:

1. Hair: Shampoo your hair WITHOUT conditioner or any other hair products. This makes it easier for the technologist to apply and remove the monitoring equipment.

2. Valuables: Please leave all valuables at home.

3. Pillow/Sleep Wear: You may bring your own pillow to be more comfortable during the night, and comfortable sleep wear. Some people are more comfortable in t-shirts/shorts.

4. Sleep Aide: If you take a sleep aid while you are here, we will ask that you remain in our sleep center for observation for at least six hours after you take it. This is for your safety.

5. Medications: Remember to bring any medications or supplies with you that you will need that night or in the morning.

6. Room/Amenities: You will have your own room with a private bathroom and shower, which will have towels, washcloth, soap & shampoo. Bring any other personal hygiene items you may wish to use. The room also has a television.

7. Questionnaire: Bring your completed questionnaire with you to the Sleep Center.

8. Arrive on Time: To ensure optimal time for your sleep appointment, please be sure to arrive on time, or at least 15 minutes prior to your appointment time. If you are late, we may not be able to complete your testing in the time available.

9. Forms: After greeting your technologist, you will be presented with a few more forms to complete (medical release form and general questions to make sure we understand your sleep habits).

10. Study Preparations: The hook-up for the study generally takes about an hour. In this time period, you will watch an educational video that explains the testing and hook up more thoroughly. You will also be given ample time to unwind, relax and get comfortable with your surroundings.

11. Television/Reading: You may watch TV or read prior to going to sleep, but in order to get enough sleep time to try to get testing done in one night, we ask that the TV and lights get turned off at 10:00. In order to have a good quality study, we need at least 7 hours of recording time.

12. Sleep Position: You can sleep in any position you are comfortable in. However, at some point during the night, the technologist may ask you to try to sleep on your back for a period of time to see if you have respiratory events in that position.

13. Comfort: It is very important to us that you are comfortable during the night. If you have any discomfort or other issues please let your tech know so we can assist you.

14. End of Testing: In most cases, you will be awakened at 6 a.m., however, the technologist may opt to have you sleep a little longer if additional data is needed. ***It is important that you let your technologist know if you need to leave by a certain time.***

15. Test Results: The technologist is not allowed to give test results. You should contact or follow up with your referring physician (the physician who ordered your sleep study) to discuss the results of your sleep study.

AFTER THE STUDY:

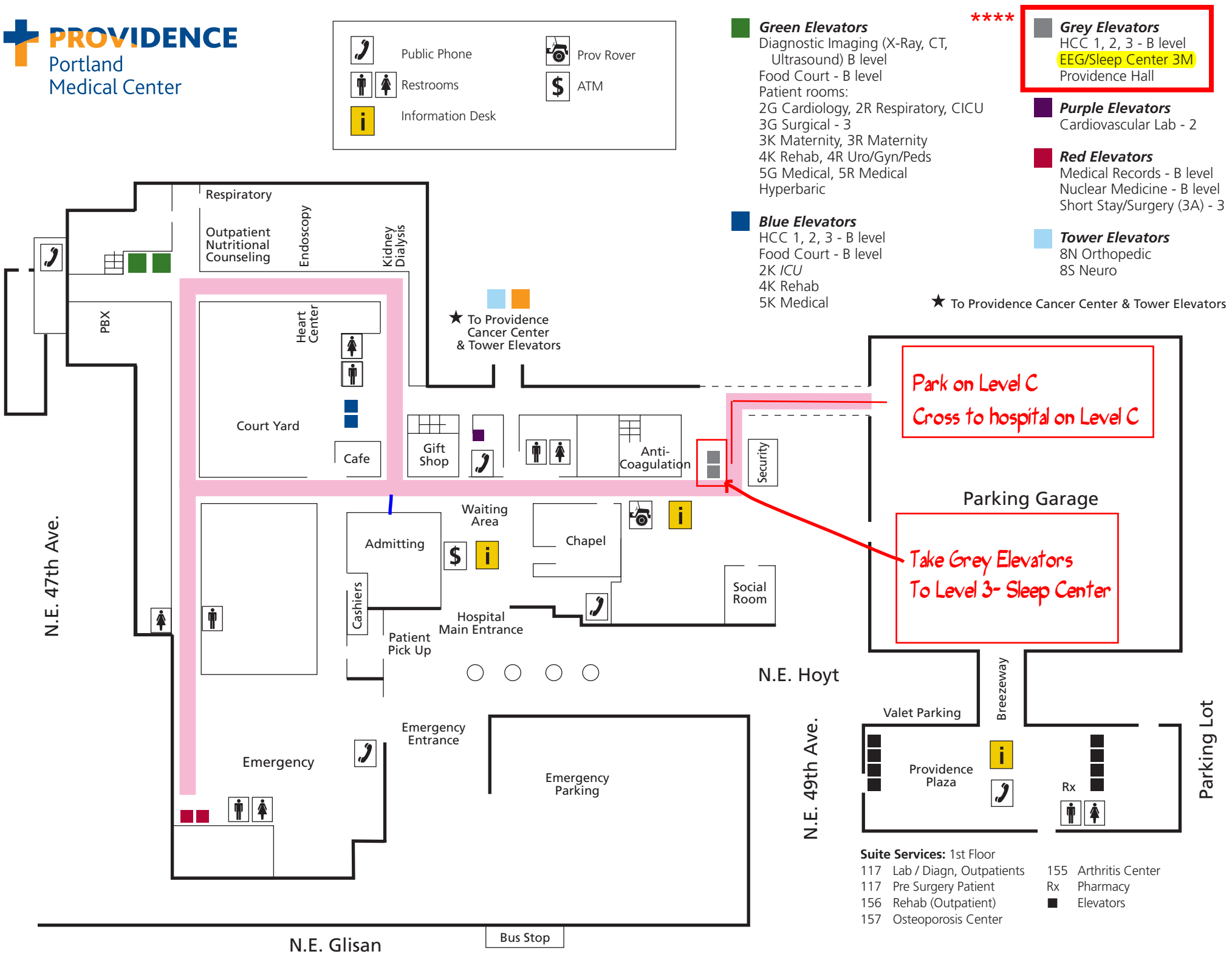
1. Paste/Glue: We will make every attempt to remove the paste and glue, however despite our best efforts you may find some left on your scalp. You can remove any paste residue w/ warm water and soap. IF glue was used to adhere electrodes and you have residue left, simply wipe the affected area with a cotton ball that has a little cooking oil (like olive oil) or baby oil on it. Use this on the area of the scalp along with a comb to help lift the glue off. Apply liberal amounts of shampoo thoroughly before adding water, then follow normal shampooing instructions.

2. Skin Integrity: Some people with very sensitive skin may get some small skin abrasions from where the electrodes were applied (usually on the face). If this occurs leave open to air, clean with soap and water. If it gets worse, please call your physician.

3. Sleep Study Report: It can take up to 7 days for your physician to receive the final report from the reading sleep physician. Please allow ample time between your study and follow-up appointment with your physician to discuss results.

4. Second Sleep Study: In many cases, it will be necessary for people to return to Sleep Center to complete the testing using CPAP. This is what we call a "titration" study. If your doctor feels this is right for you, you may call our secretary to schedule the test. In some cases, our secretary might contact you. This would mean your doctor has already given us an order for the testing. The process for the second study will be the same. The only difference is in addition to the original hook up; you will also be trying the CPAP mask.

Thanks again for choosing Providence! If you have any questions please feel free to call and ask, or ask your technician during your study.


PROVIDENCE
Portland
Medical Center
Public Phone
Restrooms
Information Desk
Prov Rover
ATM
Green Elevators
Diagnostic Imaging (X-Ray, CT, Ultrasound) B level
Food Court - B level
Patient rooms:
2G Cardiology, 2R Respiratory, CICU
3G Surgical - 3
3K Maternity, 3R Maternity
4K Rehab, 4R Uro/Gyn/Peds
5G Medical, 5R Medical
Hyperbaric
Blue Elevators
HCC 1, 2, 3 - B level
Food Court - B level
2K ICU
4K Rehab
5K Medical
****
Grey Elevators
HCC 1, 2, 3 - B level
EEG/Sleep Center 3M
Providence Hall
Purple Elevators
Cardiovascular Lab - 2
Red Elevators
Medical Records - B level
Nuclear Medicine - B level
Short Stay/Surgery (3A) - 3
Tower Elevators
8N Orthopedic
8S Neuro
★ To Providence Cancer Center & Tower Elevators
Respiratory
Outpatient Nutritional Counseling
Endoscopy
Kidney Dialysis
PBX
Heart Center
Court Yard
Cafe
★ To Providence Cancer Center & Tower Elevators
Gift Shop
Anti-Coagulation
Security
Park on Level C
Cross to hospital on Level C
Parking Garage
Take Grey Elevators
To Level 3- Sleep Center
Waiting Area
Admitting
Cashiers
Chapel
Social Room
Hospital Main Entrance
Patient Pick Up
N.E. 47th Ave.
N.E. Hoyt
Emergency Entrance
Emergency
Emergency Parking
N.E. Glisan
Bus Stop
N.E. 49th Ave.
Valet Parking
Breezeway
Providence Plaza
Rx
Parking Lot
Suite Services: 1st Floor
117 Lab / Diagn, Outpatients
117 Pre Surgery Patient
156 Rehab (Outpatient)
157 Osteoporosis Center
155 Arthritis Center
Rx Pharmacy
Elevators

WHAT IS A SLEEP STUDY?

Sleep Studies are not painful!

A sleep study is a recording of your sleep. While you sleep we monitor:

Brain Activity:

- Your brain activity will be monitored using electrodes placed on your head. These electrodes most commonly will be applied with a thick paste and tape. Occasionally, the technician may opt to use a glue to adhere the electrodes.

Breathing:

- A sensor will monitor your airflow from your mouth and nose. Most often it is taped on.
- Velcro belts will go around both your chest and stomach to help monitor your breathing.

Snoring:

- A small sensor will be taped on the side of your neck. This sensor shows activity on the computer monitor when you snore.

Leg movements:

- Leg muscle movement is monitored by electrodes applied with adhesive on the bottom part of your legs (between your knees and ankles).

Heart rate/rhythm:

- ECG (heart rate and rhythm) will be monitored using adhesive stickers applied on your chest.

Video:

- Your study is recorded with digital video. This provides more detail to help the Sleep Physician interpret your study. Sometimes people ask if they can have a copy of the video. We apologize, but we are unable to duplicate the video.

CPAP Treatment

- Sometimes, during the last half of the night or on a second night, a treatment called CPAP will be tried. If you are found to have sleep apnea (pauses in breathing), in some cases we may be able to apply a machine that delivers air pressure to help open airways (CPAP= continuous positive airway pressure) that includes a mask, to help treat the apnea. There are several different options of masks available. Do not hesitate to ask your technician during the night to see more options if you need them.
  a. If we are able to find the correct treatment for your sleep apnea (and your insurance allows) we may be able to provide you with a CPAP machine in the morning. This will take an additional 1-2 hours longer in the morning.
  b. If you have an average of 20 apneas per hour AND have at least two hours of actual sleep time before 3 a.m., we are allowed to try you on a CPAP machine. This is called a split-night study. Only about 1/3 of people who are found to have sleep apnea will get this type of study which, in most cases, completes diagnosis and treatment phase in one night's study.
  c. Approximately 2/3 of people who are found to have sleep apnea will require another full night of testing with CPAP to determine the appropriate setting of the machine. This is called a titration study.

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Providence Sleep Services

PROVIDENCE Health & Services

Providence Portland Medical Center
Providence St. Vincent Medical Center
Providence Milwaukie Hospital
Providence Newberg Medical Center
Providence Hood River Memorial Hospital

PATIENT IMPRINT

History Questionnaire

FULL NAME:_____ **Age:**_____
(Last) (First) (MI)

SEX: ☐Male ☐Female **WEIGHT**_____ **HEIGHT**_____

ADDRESS:_____ **PHONE:**( )_____

_____ **WORK:** ( )_____

REFERRING PHYSICIAN_____ **PHONE:**( )_____

Please list physicians you would like to receive a copy of your sleep study results:

1. Name:_____Address:_____
2. Name:_____Address:_____
3. Name:_____Address:_____

Briefly describe the nature and duration of your sleep problem:_____

_____

_____

_____

Section 1: Sleepiness

(answers may vary day to day, please give best estimate or usual range)

Do you feel excessively sleepy or fatigued during the daytime? ☐NO ☐ YES

If yes, how severe? ☐Mild ☐Moderate ☐Severe

How long have you had symptoms?_____

☐NO ☐ YES **Does sleepiness affect your job?**

Describe:_____

☐ NO ☐YES **Does sleepiness affect your home and/or social life?**

Describe:_____

☐ NO ☐YES **Does sleepiness affect your leisure time?**

Describe:_____

☐ NO ☐ YES **Do you fall asleep at times when you don't want to?**

Describe: _____

☐ NO ☐ YES **Have you had any accident/near-accidents due to sleepiness while driving?**

Describe:_____

☐ NO ☐ YES **Do you nap during the daytime?**

Describe: _____

Is the nap : ☐Intentional ☐ unintentional?

How often and for how long?_____days/week _____ hours/day

☐ NO ☐ YES **Do you awaken from your nap feeling refreshed?**

Describe: _____

Section 2: Sleep Habits

(answers may vary day to day, please give best estimate or usual range)

☐ NO ☐ YES **Do you have a bed partner?**

☐ NO ☐ YES **If so, do any of their behaviors disturb you during sleep?**

Describe: _____

☐ NO ☐ YES **Do you sleep apart?**

If so, for what reason(s)?_____

What is your usual bedtime?

On workdays?_____ ☐ AM ☐ PM

Non-work days?_____ ☐ AM ☐ PM

☐ NO ☐ YES **Do you eat within 3 hours of bedtime?**

Describe:_____

☐ NO ☐ YES **Do you drink alcohol within 3 hours of bedtime?**

Describe:_____

☐ NO ☐ YES **Is your bed/bedroom comfortable?**

Describe:_____++_____

☐ NO ☐ YES **Do you watch TV or read in bed, or use a computer before sleep?**

Describe: _____

On average, how long does it take you to fall asleep? _____Minutes

☐ NO ☐ YES **Do you experience insomnia?**

Is the difficulty: ☐ Getting to sleep initially
☐ Staying asleep
☐ Awakening too early

Describe: _____

☐ NO ☐ YES **Do you use sleeping pills or alcohol to help you get to sleep?**

Describe: _____

What time do you normally wake up?

On workdays?_____ ☐ AM ☐ PM

Non-work days?_____ ☐ AM ☐ PM

When permitted to choose your own schedule (weekends, vacation, ect.) what are your ideal bedtime and awakening times?

Do you awaken feeling refreshed and ready to begin the day?

☐Always ☐Usually ☐Sometimes ☐Rarely ☐Never

☐ NO ☐ YES **Do you awaken with headaches?**

Describe: _____

On average, how many times are you aware of awakening during the night?_____

For what reason(s) do you wake?_____

☐ NO ☐ YES **Do you awaken gasping?**

Describe:_____

☐ NO ☐ YES **Do you awaken with heartburn and/or reflux?**

Describe: _____

How many times during the night do you awaken to use the bathroom?_____

On average, how long does it take you to get back to sleep?_____

☐ NO ☐ YES **Do you sleep with the head of your bed elevated?**

Describe: _____

Estimate the percentage of a typical night that you spend sleeping on your:

_____ %	_____ %	_____ %	_____ %
Back	Stomach	Left	Right

☐ NO ☐ YES **Do you sleep places other than your bed?**

Describe: _____

☐ NO ☐ YES **Have you been told you snore?**

If yes, how loud? Mild Moderate Severe

☐ NO ☐ YES **Does your snoring disturb others?**

Describe: _____

☐ NO ☐ YES **Have you been told you stop breathing during sleep?**

Describe: _____

If yes, how long do the episodes last?_____

Section 3: Sleep/Wake Behaviors

(answers may vary day to day, please give best estimate or usual range)

☐ NO ☐ YES **When you try to relax in the evening or sleep at night, do you have unpleasant, restless feelings in your legs that can be relieved by waking or movement?**

Describe: _____

If so, how many nights per week, on average, does this occur?_____

☐ NO ☐ YES **Do your legs make it difficult for you to get to sleep or awaken you at night?**

Describe: _____

☐ NO ☐ YES **Do your leg movements disturb/awaken your bed partner?**

Describe: _____

☐ NO ☐ YES **Have you been told that you talk during sleep?**

Describe: _____

☐ NO ☐ YES **Have you been told, as an adult, that you sleepwalk?**

Describe: _____

☐ NO ☐ YES **Do you ever act out dreams during sleep?**

Describe: _____

☐ NO ☐ YES **Have you ever injured yourself or your bed partner during sleep?**

Describe: _____

☐ NO ☐ YES **Have you been told that you grind your teeth while sleeping?**

Describe: _____

☐ NO ☐ YES **Have you been told that you had a seizure while sleeping?**

Describe: _____

☐ NO ☐ YES **Have you experienced bedwetting as an adult?**

Describe: _____

☐ NO ☐ YES **Have you ever felt paralyzed (complete body involvement) while lying in bed waiting to go to sleep or after awakening from sleep?**

Describe: _____

☐ NO ☐ YES **Have you experienced hallucinations while falling asleep or while waking up?**

Describe: _____

Do you experience buckling of your knees or uncontrollable muscle weakness with:

☐ NO ☐ YES **Laughter?**

Describe: _____

☐ NO ☐ YES **Anger?**

Describe: _____

Section 4: Sleep/Wake Behaviors
(answers may vary day to day, please give best estimate or usual range)

☐ NO ☐ YES **Do you have difficulty breathing through one or both sides of your nose?**

Describe: _____

☐ NO ☐ YES **Do you use nasal spray(s)?**

Describe: _____

☐ NO ☐ YES **Have you had any surgery on your nose and/or throat?**

Describe: _____

Section 5: Weight/Diet History
(answers may vary day to day, please give best estimate or usual range)

How does your current weight compare to what you weighed 5 years ago?_____

_____.

☐ NO ☐ YES **Do you drink caffeinated beverages (coffee, tea, soda, energy drinks)?**

If so, what and how much per day:

Weekday:_____

Weekend:_____

☐ NO ☐ YES **Do you drink alcoholic beverages?**

If so, what and how much per day:

Weekday:_____

Weekend:_____

☐ NO ☐ YES **Do you currently smoke?**

If so, how much per day?_____

Section 6: Family History
(answers may vary day to day, please give best estimate or usual range)

☐ NO ☐ YES **Have any of your first-degree relatives (parents, siblings, children) been diagnosed with sleep apnea?**

Describe: _____

☐ NO ☐ YES **Have any of your first-degree relatives (parents, siblings, children) been diagnosed with narcolepsy?**

Describe: _____

Section 7: Past Medical History
(answers may vary day to day, please give best estimate or usual range)

☐ NO ☐ YES **Have you had any previous sleep studies?**

Describe: _____

Have you ever been diagnosed with:

☐ NO ☐ YES Hypertension (high blood pressure)?
☐ NO ☐ YES Heart attack/myocardial infarction?
☐ NO ☐ YES Congestive heart failure?
☐ NO ☐ YES Atrial fibrillation?
☐ NO ☐ YES Stroke?
☐ NO ☐ YES Gastroesophageal reflux disease (GERD)/heartburn?
☐ NO ☐ YES Lung disease (asthmas/COPD/chronic bronchitis/emphysema)?
Describe: _____
☐ NO ☐ YES Do you use oxygen?
Describe: _____
☐ NO ☐ YES Diabetes?
☐ NO ☐ YES Liver or kidney disease?
☐ NO ☐ YES Depression?
☐ NO ☐ YES Post-Traumatic Stress Disorder (PTSD)?
☐ NO ☐ YES Anxiety/panic attacks?
☐ NO ☐ YES Rheumatoid arthritis?
☐ NO ☐ YES Fibromyalgia?
☐ NO ☐ YES Chronic pain?
Describe: _____
☐ NO ☐ YES Parkinson's Disease?
☐ NO ☐ YES Seizures/epilepsy?
☐ NO ☐ YES Alcoholism?
Describe: _____
☐ NO ☐ YES Drug abuse or dependence?
Describe: _____

Please list any current/chronic medical conditions not identified above:

_____

_____

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Providence Sleep Services

PROVIDENCE Health & Services

Providence Portland Medical Center
Providence St. Vincent Medical Center
Providence Milwaukie Hospital
Providence Newberg Medical Center
Providence Hood River Memorial Hospital

PATIENT IMPRINT

History Questionnaire

Section 8: Medications

(answers may vary day to day, please give best estimate or usual range)

Medication Allergies:

Medication Allergy	Reaction

Current medications (prescription, over-the-counter, and vitamins/supplements):

Name of Drug	Dosage	Frequency Taken	Reason	Duration of use

Section 9: EPWORTH Sleepiness Score

(answers may vary day to day, please give best estimate or usual range)

- How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?
- 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 or sleep.
1 = ***slight*** chance of dozing or sleeping
2 = ***moderate*** chance of dozing or sleeping
3 = ***high*** chance of dozing or sleeping

Situation	**Chance of Dozing or Sleeping**
Sitting and reading	☐ 0 (never) ☐ 1 (slight) ☐ 2 (moderate) ☐ 3 (high)
Watching TV	☐ 0 (never) ☐ 1 (slight) ☐ 2 (moderate) ☐ 3 (high)
Sitting inactive in a public place	☐ 0 (never) ☐ 1 (slight) ☐ 2 (moderate) ☐ 3 (high)
Being a passenger in a motor vehicle for an hour or more	☐ 0 (never) ☐ 1 (slight) ☐ 2 (moderate) ☐ 3 (high)
Lying down in the afternoon	☐ 0 (never) ☐ 1 (slight) ☐ 2 (moderate) ☐ 3 (high)
Sitting and talking to someone	☐ 0 (never) ☐ 1 (slight) ☐ 2 (moderate) ☐ 3 (high)
Sitting quietly after lunch (no alcohol)	☐ 0 (never) ☐ 1 (slight) ☐ 2 (moderate) ☐ 3 (high)
Stopped for a few minutes in traffic while driving	☐ 0 (never) ☐ 1 (slight) ☐ 2 (moderate) ☐ 3 (high)
TOTAL (add up the scores)	_____

x _____
Patient Signature Date/Time

x _____
Sleep Technologist Reviewing Document Date/Time