



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 understand clearly which Sleep Center you are scheduled for:

Providence St. Vincent Medical Center
9155 SW Barnes Rd, Suite 409
Portland, Oregon 97225
Phone: 503-216-2010
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. **Pediatrics:** In order to assure the safety of any child \leq 18 years of age it is required per lab protocol that an Adult Legal guardian be present with said child at ALL times. ***Otherwise the sleep study cannot be preformed.***
4. **Special Needs:** If you have other special needs, please notify us in advance so that we may be better prepared to care for 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...
5. **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.

6. **Sleep Questionnaire:** Complete the enclosed questionnaire. This will help our sleep physicians interpret your study more accurately.
7. **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 (7:30am – 7:00pm). After normal business hours or on weekends, call and leave a message for the staff.
8. **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.
9. **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.

First Floor

503-216-1234

EMPLOYEE/PHYSICIAN
NORTH PARKING GARAGE

- Purple Elevators**
- Heart Center (2nd floor)
 - Cath labs
 - Cardiac Operating Room
 - Coronary Care Unit (CCU)
 - ICVR
 - Maternity (3rd floor)
 - Rehab (LL)
 - Oregon Med. Laser Center (LL)
 - Pathology (LL)
 - Emergency (LL)

- Green Elevators**
- Cafeteria (2nd floor)
 - Chapel (2nd floor)
 - Pastoral Services (2nd floor)
 - Medical Foundation (2nd floor)
 - North Dining Room (2nd floor)
 - Conference Room 1-6 (2nd floor)
 - Beauty Shop (2nd floor)
 - Board Room (2nd floor)
 - Administration (2nd floor)
 - Patient Rooms (4th - 9th floor)
 - Conference Room 8-12 (LL)

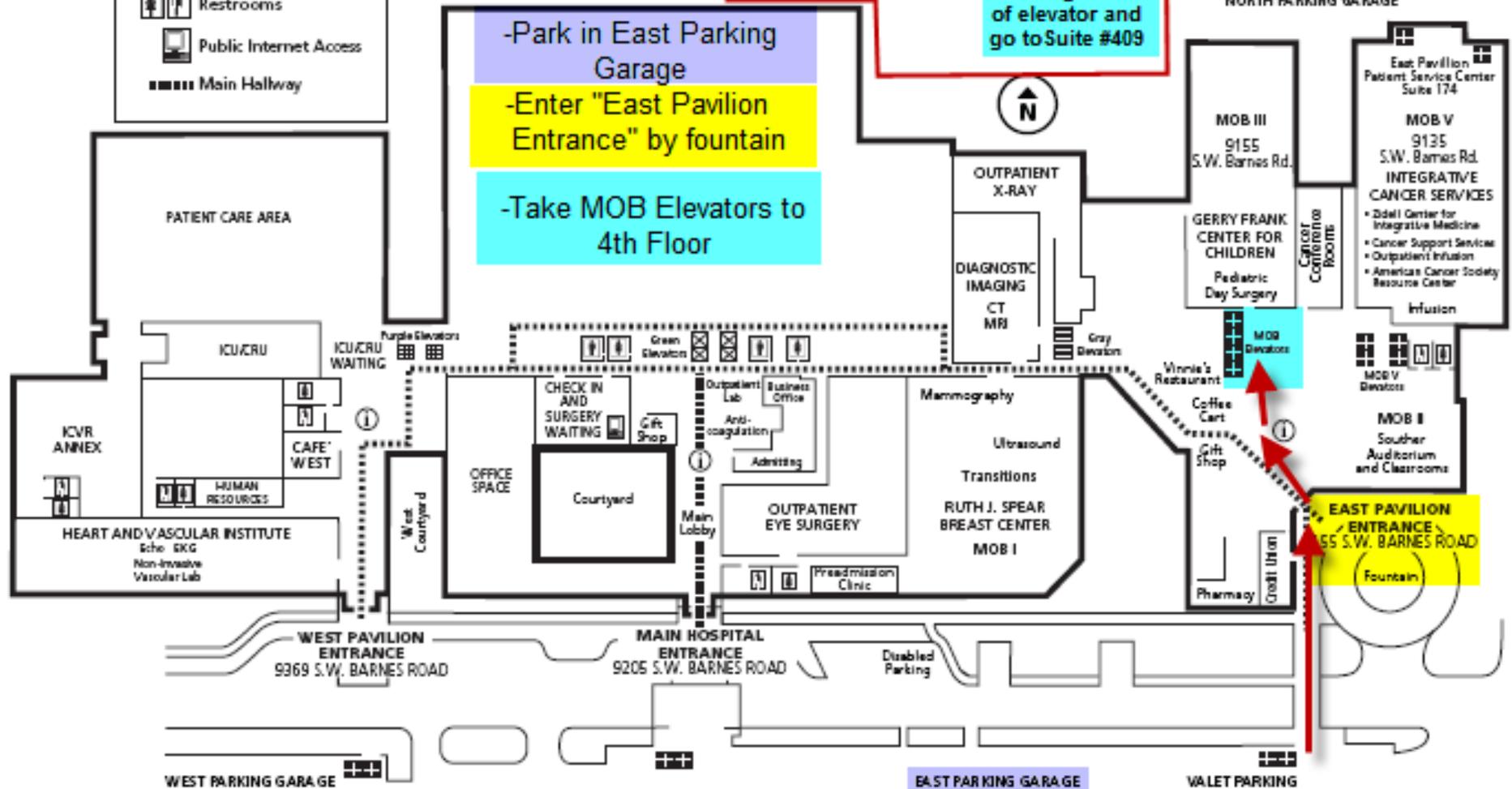
- Gray Elevators**
- Dept. of Medicine (LL)
 - Nuclear Medicine (LL)
 - Anticoagulation Clinic (LL)
 - Radiation Oncology (LL)
 - Outpatient Dietician (LL)
 - Faculty Practice (LL)

- MOB Elevators**
- Oncology and Hematology Care (2nd floor)
 - Physical Therapy/Rehab (3rd floor)
 - Brain Institute (3rd floor)
 - Postpartum Care/Breastfeeding Center (7th floor)
 - Sleep Disorders Center (4th floor)
 - Traveler's Clinic (3rd floor)

Take right out
of elevator and
go to Suite #409

- Information Desk
- Restrooms
- Public Internet Access
- Main Hallway

- Park in East Parking Garage
- Enter "East Pavilion Entrance" by fountain
- Take MOB Elevators to 4th Floor



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

PATIENT IMPRINT

Providence Sleep Services

Child History Questionnaire

CHILD'S FULL NAME: _____ Age: _____
(Last) (First) (MI)

SEX: Male Female

ADDRESS: _____ PHONE: () _____

REFERRING PHYSICIAN _____ PHONE: () _____

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

- Name: _____ Address: _____
- Name: _____ Address: _____
- Name: _____ Address: _____

Section 1: Sleep History (answers may vary day to day, please give best estimate or usual range)

- NO YES **Snoring?**
- NO YES **Snorting or gasping?**
(appears to have a hard time getting air)
- NO YES **Restless sleep?**
(moves around a great deal; kicks, thrashes, sheets and blankets in disarray in morning)
- NO YES **Waking during the night?**

How many nights per week? _____
How many times per night? _____

Duration of episodes (if present)

- Less than 5 minutes
- 5 – 15 minutes
- 15 – 30 minutes
- 30 – 60 minutes
- Greater than 60 minutes

- NO YES **Sleepwalking?**
(walks or runs without appearing fully awake)

How many nights per week? _____
How many times per night? _____



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Child History Questionnaire

6. NO YES **Screams or cries in sleep?**
(seems frightened, does not respond easily to parental soothing)

How many nights per week? _____
How many times per night? _____

7. NO YES **Wets the bed?**
(if child is more than 3 years old)

How many nights per week? _____

8. NO YES **Rocking or head banging during sleep?**

How many nights per week? _____
How many times per night? _____

Please check all that apply to your child:

9. **Duration of episodes (if present)**

- None
- Once a day
- Twice a day
- Three times a day
- Four or more times a day

10. **Falls asleep easily during daytime activities**

- In school
- Watching television
- Eating dinner
- During an exciting event (birthday party)
- Does not apply

11. **Tends to be cranky and irritable frequently in the....**
(when not sick or hungry)

- Morning
- Afternoon
- Evening
- Does not apply

12. **Are you or the child's teacher, worried about the following:**

- | | Parent | Teacher | Neither |
|--|--------------------------|--------------------------|--------------------------|
| • Short attention span for a child his/her age | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • High activity level compared to other children of the same age | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Child seems lazy or poorly motivated | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



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PATIENT IMPRINT

Providence Sleep Services

Child History Questionnaire

13. Where does the child sleep?

- In a room alone
- In a room with brothers/sisters
- In a room with parents (or other adults)
- In a room alone partially, later with parents (or other adults) partially

Section 2: Obesity

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

Estimated Weight _____

Estimated Height _____

NO YES

Any recent weight change?

Increased

Decreased

For how long:

Weight 6 months ago _____

Weight 1 year ago _____

Weight _____ years ago _____

Section 3: Previous Medical Attention to Present Illness

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

Physicians, dates, tests, diagnoses, treatments:

Section 4: Other Past Medical History

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

Please list any current/chronic medical conditions:
