**La Porte Hospital**

## Sleep Disorders Center

# VERY IMPORTANT INFORMATION

### Instructions for in-lab patients and HST (Home Sleep Test) patients

- Plan to arrive at the La Porte Hospital Emergency Room at the time specified in the enclosed letter for registration.
- Complete the forms in this packet and bring them with you the night of your study or the day or your HST pick-up.
- If you need to take any medications before bedtime, bring them with you (this includes something as basic as aspirin or Tylenol). Medications CANNOT be provided to you by the sleep center.
- In-lab patients must have your hair clean and dry the day of your test.
- Do not wear makeup or use any products in your hair. Do not apply any heavy creams or lotions to your skin because they alter the quality of your test.
- Bring something to sleep in that is 2-piece and loose-fitting if you are an in-lab study.
- ALL patients: Bring your insurance card and a photo ID (driver's license)
- Go about your normal day; this includes performing all your usual activities and taking all of your usual medications.
- **Try to avoid:**
    - Naps unless they are a usual part of your day. If you do nap, make it slightly shorter than usual.
    - Excessive amounts of caffeine, more than normal (coffee, tea or cola beverages).
- If you have special needs (i.e. hospital bed, bedside commode, oxygen, nebulizer, etc.) and you have not already advised your scheduler, call 219-326-2444 prior to your appointment (Mon – Fri, between the hours of 8:00 am – 7 pm). In some cases, it may be necessary for you to bring your equipment from home.
- If you have not yet spoken to the pre-registration department, call the number listed on the letter at the front of this packet for pre-registration.

# Common Questions Regarding Sleep Testing

**What symptoms might lead my doctor to suspect I have a sleep disorder?**
Some symptoms include excessive daytime sleepiness, fatigue, depression, insomnia, hypertension, morning headaches, poor concentration and memory loss. Perhaps your bed partner has complaints of loud snoring/snorting, teeth grinding, active leg/body movements during sleep and many others.

**What is a sleep test?**
The technician assigned to you will apply various monitors to your head, chest, legs, finger, nose, mouth and throat. These specialized devices will record the details of your sleep and tell the doctor about the quality of sleep you are getting, oxygen level, heart rhythm, breathing pattern and other things occurring while you sleep.

**What is an HST?**
The HST is a "Home Sleep Test" based upon your medical history and symptoms it may be determined that this test is more suitable for you. The HST monitors respiratory, effort, snore, oxygen and pulse. HST is used to determine whether or not a patient has sleep apnea.

**How long does this test take?**

- **In-lab:** In order to obtain an accurate account of all the complicated functions of sleep, you are expected to stay for six to eight hours the night of your test. It will take the technician approximately 45 minutes to apply the recording devices and approximately 15 minutes to calibrate the devices to you. During the calibration, you will follow verbal commands given by the technician.

- **HST:** The HST is started by the patient at the patients' natural sleep time and ended at their natural wake time. The device has an average battery life of 10 hours

**What if I need something or have to go to the restroom in the middle of the night?**
Once you are connected to the testing equipment, you can move freely in bed. If you need to leave the bed for any reason, state your request out loud and a technician will be there promptly to assist you.

**What is CPAP? What does CPAP do?**
CPAP stands for Continuous Positive Airway Pressure. It is a small bedside unit that has tubing and a small mask that is placed gently over your nose and delivers air into your airway. It assists your body in breathing while allowing you to rest so that breathing irregularity does not keep you from sleeping properly. If the technician observes a breathing problem during your study, he/she may awaken you to continue the test with one of these devices.

**Will there be TV in the room?**
Each room has a TV however; at some point in the evening the technician will ask that you attempt to fall asleep without the TV on for clinical reasons.

**Will I have to pay for parking?**
No, there is free parking at the hospital. Please use the "ER Entrance" and there you will be registered for your sleep study before being taken to the Sleep Lab.

**Will I be able to have a family member stay with me?**
No, we do not have additional rooms for family to stay. If a caregiver is required, the caregiver is to stay in the room monitoring the patient.

***PLEASE DO NOT ARRIVE MORE THAN 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME***

# SLEEP DISORDERS CENTER

## Patient Information Summary

Name: _____ DOB: _____ Today's Date: _____

Height: _____ft_____in Weight: _____ lbs Neck Circumference: _____in *(staff can measure if unsure)*

**A) CHIEF COMPLAINT – Describe your sleep/wake problems and how long it has been present:** _____

_____

_____

**B) TYPICAL SLEEP TIMES**

| | | |
|---|---|---|
| What time do you go to bed? | Weekdays: _____ | Weekends: _____ |
| What time do you get out of bed? | Weekdays: _____ | Weekends: _____ |
| How long do you nap during the day? | Weekdays: _____ | Weekends: _____ |
| How much time do you spend asleep? | Weekdays: _____ | Weekends: _____ |

How many times do you awaken from sleep each night on average? _____

What do you think causes this or what do you notice at that moment? _____

**C) PAST MEDICAL HISTORY – Check all that apply:**

| | | | |
|---|---|---|---|
| ☐ Hypertension | ☐ Asthma | ☐ **C**ongestive **H**eart **F**ailure | ☐ **C**hronic **O**bstructive **P**ulmonary **D**isease |
| ☐ Heart Attack | ☐ Diabetes | ☐ **C**oronary **A**rtery **D**isease | ☐ Stroke/**T**ransient **I**schemic **A**ttack |
| ☐ Impotence | ☐ Depression | ☐ Home Oxygen | ☐ Hypothyroidism |
| ☐ Emphysema | ☐ Epilepsy/Seizure - Date of most recent seizure: _____ | | |

**D) CURRENT MEDICATIONS – List all prescription and non-prescription medications. Use space below if necessary.**

| | *Name of Medication* | *Dose* | *Times a Day* |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |

**ALLERGIES:** _____

**Patient Label**

# SLEEP DISORDERS CENTER
## Patient Information Summary

**E) PAIN – Are you currently having any pain?** ☐ Yes ☐ No **If yes, please describe the pain below.**

Origin: _____ Onset: _____

Location: _____ Quality (i.e. burning, dull ache): _____

Intensity: Rate on a scale of 0-10 (0 = no pain and 10 = unbearable) 0 1 2 3 4 5 6 7 8 9 10

Frequency/Duration: _____

Aggravating/Relieving Factors: _____

Pain Management History: _____

Present Pain Management Regimen and Effectiveness: _____

**F) FAMILY SLEEP HISTORY – Do any of your relatives have a sleep disorder?** ☐ Yes ☐ No

Check all family members that apply: ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Son ☐ Daughter

Check the type of sleep disorder(s): ☐ Sleep apnea ☐ Narcolepsy ☐ Restless legs ☐ Insomnia ☐ Other

**G) SOCIAL HISTORY – Complete the following general information.**

Check Appropriate: ☐ Live and sleep alone ☐ Someone sleeps in a room nearby ☐ Have roommate ☐ Married

What is your occupation? _____

Number of caffeinated drinks per day: _____ Number of alcoholic drinks per week: _____

Number of tobacco products per day: _____ Number of years smoking: _____

**H) REVIEW OF SYSTEMS – Please check those issues that apply to you.**

**Ear, nose, mouth, throat:**
☐ Frequent sore throat
☐ Hay fever/allergies
☐ Sinus trouble
☐ Tonsillectomy
☐ TMJ Syndrome

**Respiratory symptoms:**
☐ Shortness of breath w/exertion
☐ Asthma / Emphysema
☐ Chronic cough

**Neurological problems:**
☐ Stroke or TIA
☐ Seizure
☐ Neuropathy
☐ Major head injury

**Kidney problems:**
☐ Known kidney disease
☐ Kidney stones
☐ Prostate problems

**Psychiatric issues:**
☐ Depression
☐ Chronic Anxiety
☐ Panic attacks

**Cardiovascular symptoms:**
☐ Recurrent Chest pain
☐ Palpitations or arrhythmia
☐ High Blood Pressure
☐ History of MI / heart attack
☐ Congestive Heart Failure (CHF)

**Gastrointestinal symptoms:**
☐ Heartburn/GERD
☐ Mononucleosis or liver disease

**Musculoskeletal problems:**
☐ Neck or back problems
☐ Arthritis

**Endocrine or gland problems:**
☐ Thyroid disorder
☐ Heat or cold intolerance
☐ Diabetes

**Constitutional symptoms or issues:**
☐ Poor appetite
☐ Weight gain over past two years

*How Much?* _____ lbs

**Patient Label**

# SLEEP DISORDERS CENTER

Patient Information Summary

**I) SLEEP COMPLAINTS/PROBLEMS - Circle the number for each complaint/problem listed using the scale below.**

**SCALE: 0 = Never 1 = Rarely 2 = Sometimes 3 = Often 4 = Very Often 5 = Always**

| The following list includes possible complaints or problems associated with ***sleep at night***. | |
|---|---|
| 0 1 2 3 4 5 | Snoring disturbs others |
| 0 1 2 3 4 5 | Gasp or wake up from sleeping choking |
| 0 1 2 3 4 5 | Stop breathing for short periods |
| 0 1 2 3 4 5 | Feel paralyzed when falling asleep or waking up |
| 0 1 2 3 4 5 | Have near hallucinations or dreamlike images when falling asleep or just waking up |
| 0 1 2 3 4 5 | Have leg cramps at night |
| 0 1 2 3 4 5 | Uncomfortable, crawling sensation in legs that is relieved by moving or walking |
| 0 1 2 3 4 5 | Jerk your arms or legs at night |
| 0 1 2 3 4 5 | Sleep restlessly |
| 0 1 2 3 4 5 | Have aches or pains at night – describe: _____ |
| 0 1 2 3 4 5 | Have problems falling asleep at night or staying asleep |
| 0 1 2 3 4 5 | Lie away feeling depressed, worried or anxious |
| 0 1 2 3 4 5 | Grind you teeth at night |
| 0 1 2 3 4 5 | Frightening dreams or nightmares |
| 0 1 2 3 4 5 | Walk in sleep |
| 0 1 2 3 4 5 | Talk in sleep |
| 0 1 2 3 4 5 | Sleep often disturbed by your partner |
| 0 1 2 3 4 5 | Sleep often disturbed by noise or pets |
| 0 1 2 3 4 5 | Smoke at night |
| 0 1 2 3 4 5 | Eat in bed at night |
| 0 1 2 3 4 5 | Watch TV in bed |
| 0 1 2 3 4 5 | Wake up with nausea or heartburn |
| 0 1 2 3 4 5 | Wake up with chest pain |

| The following list includes possible <u>DAYTIME</u> complaints or problems associated with sleep. | |
|---|---|
| 0 1 2 3 4 5 | Feel unrefreshed in the morning after sleep |
| 0 1 2 3 4 5 | Find it hard to wake up in the morning |
| 0 1 2 3 4 5 | Irritable |
| 0 1 2 3 4 5 | Unable to concentrate |
| 0 1 2 3 4 5 | Poor memory during the day |
| 0 1 2 3 4 5 | Yawn frequently during the daytime |
| 0 1 2 3 4 5 | Feel drowsy or sleepy during the day |
| 0 1 2 3 4 5 | Daytime sleepiness interferes with normal activities |
| 0 1 2 3 4 5 | Daytime fatigue |
| 0 1 2 3 4 5 | Have hallucinations or dream-like mental images during the day |
| 0 1 2 3 4 5 | Have sudden physical weakness or paralysis when laughing, angry or other emotional situations |
| 0 1 2 3 4 5 | Have daytime sleep complaints that seem to go in cycles or only appear at certain times *(example: only in evenings; every 10 days; when you sleep away from home)* |

**Patient Label**

## J) EPWORTH SLEEPINESS SCALE

**Using the scale below, indicate the likelihood you would fall asleep in the following situations. The 0-3 scale refers to your usual way of life in recent times.**

**0 = Would never doze 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing**

_____ Sitting and reading.

_____ Sitting quietly after lunch.

_____ Watching TV.

_____ As a passenger in a car for an hour without a break.

_____ In a car, while stopped for a few minutes in traffic.

_____ Sitting and talking to someone.

_____ Lying down to rest in the afternoon.

_____ Sitting, inactive in public place (i.e. theater or a meeting)

_____ **TOTAL SCORE**

## K) CLAUSTROPHOBIA

**Do you experience claustrophobia (fear of being enclosed in a small space or room)?**

☐ No ☐ Yes If yes, how would you rate the symptoms: ☐ Mild ☐ Moderate ☐ Severe

**Signature:** _____ **Date/ Time:** _____

***If there are other physicians you would like to receive a copy of the test results, please list their names, phone numbers and addresses here:***

_____

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**Patient Label**

# SLEEP DISORDERS CENTER

## Patient Information Summary / Sleep Log

**Instructions:**

1. Leave the times you are awake BLANK.
2. SHADE, crosshatch, or color in the times when you sleep.
3. Put an ARROW DOWN (↓) whenever you lie down to sleep.
4. Put an ARROW UP (↑) whenever you awaken, including naps.
5. Put "M" for meals, "S" for snacks, and "D" for alcoholic drinks.
6. Include notes below each week or on the back.

**EXAMPLE:**

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | *Noon* | | | | | | | | | | | | | | | *Midnight* | |
| *DATE:* | 6 A | 7 | 8 | 9 | 10 | 11 | 12 P | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 A | 1 | 2 | 3 | 4 | 5 |
| | | | ↑ | | | | M↓ | | ↑ | | | | | | D S | ↓ | | | | | | | ↑ S | ↓ |

**FIRST WEEK:**

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| | | | | | | | *Noon* | | | | | | | | | | | | | | | *Midnight* | |
| *DATE:* | 6 A | 7 | 8 | 9 | 10 | 11 | 12 P | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 A | 1 | 2 | 3 | 4 | 5 |
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**SECOND WEEK:**

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| | | | | | | | *Noon* | | | | | | | | | | | | | | | *Midnight* | |
| *DATE:* | 6 A | 7 | 8 | 9 | 10 | 11 | 12 P | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 A | 1 | 2 | 3 | 4 | 5 |
| | | | | | | | | | | | | | | | | | | | | | | | | |
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Patient Label