Consultants in Neurology www.neurokc.com
913.894.1500 or 800.753.6992

8550 Marshall Drive
Suite 100
Lenexa, Kansas 66214
913-894-1500

5500 N Oak Trafficway
Suite 203
Kansas City, MO 64118
913-894-1500

SLEEP STUDY INFORMATION

Your scheduled appointment time and date is:
___:_____ PM on _____

****ARRIVE ON TIME and NOT EARLY for your scheduled Sleep Study*****

The building is locked for your security during the evening hours. At the main entrance, we have an intercom and a video camera. Press the intercom button, which alerts the sleep technician. They will then come and escort you to the sleep lab for your testing. Please be patient. The technician may be with another patient.

WHAT TO BRING:

You will have time to change into nightclothes and get ready for bed, as you do at home. If you are male, you must wear running shorts, sweat pants, or pajama bottoms. You may wear a shirt if you like, but it is not necessary. If you are female, you may wear a night gown, a large shirt, or pajamas. Please feel free to bring your favorite pillow from home however, electric blankets are prohibited. You may also want to bring an overnight bag, as you would for an overnight stay at a hotel. Flat Screen Satellite TV's are available for your comfort; you may also want to bring reading materials, or something to work on before Lights Out.

WHAT HAPPENS DURING THE STUDY:

During preparation for sleep monitoring, various small sensors will be applied to the scalp, face, chest, and legs. These monitoring devices are not painful and are designed to be as comfortable as possible while you sleep. Please avoid using hair spray, lotions, face creams or makeup prior to the test. Male patients not having beards should be clean-shaven. The study will be recorded digitally for later review of abnormalities observed during the study. The technician will monitor your sleep throughout the night from a nearby room. Please remove any hair weaves, braids, or bonds prior to testing. Also, during your study you will likely be asked to remove your watch. There will be a photo taken of you prior to testing.

WHAT HAPPENS FOLLOWING THE STUDY:

The sleep study and its analysis and interpretation are part of a complex process. Many hours of work are required by a trained sleep technologist, who processes or "scores" the large amount of data recorded during the study. The information is then interpreted by a sleep specialist with special knowledge of sleep and its disorders. Because this is a time-consuming process, results may take several weeks to be evaluated. You will be contacted as soon as your results are ready.

PLEASE REVIEW THE DAY OF YOUR STUDY:

- **DO NOT** take naps during the day of your study.
- **DO NOT** eat a large or spicy meal immediately before coming in for your study.
- **DO NOT** eat or drink any food with **caffeine** such as COFFEE, TEA, SODAS, OR CHOCOLATE, after 3pm before your study.
- **DO NOT** drink alcoholic beverages on the same evening of the study.
- **BEFORE** coming to the sleep center, **wash and dry your hair, and do not apply hair sprays, oils, gels, lotion or night creams.** Men, not having beards, please come clean-shaven. You will probably want to take a **bath** or **shower** prior to coming in. Also, **no fingernail polish**, weaves, or extensions.
- **TAKE** your medications as usual, or as your doctor recommended. Bring current list of your medications.
- **PLEASE** bring comfortable sleep attire and toiletries.
- **PLEASE have this packet of paperwork completed upon arrival for your study.**
- **If** you need to contact someone or leave a message for the sleep center in the evening (after 4:30 PM), Please call (913) 827-4518 for the Lenexa Location or (913) 827-4259 for the Kansas City (Creekwood) Location.

You will be contacted with the results of your sleep study according to the option selected on your Authorization To Disclose Sleep Study Results.

If I must cancel my Sleep Study and/or PAP titration appointment(s), I understand that it is <u>my responsibility</u> to cancel by phone A MINIMUM OF ONE <u>BUSINESS DAY</u> <u>24 hours in advance</u> meaning MON – FRI. Failure to cancel will result in a $250.00 fee.

X_____ Signed in the New Patient Paperwork _____

Patient Signature Date

If you need to Re-Schedule or cancel your appointment, please call the scheduling team at:

(913) 827-4507 between 8:00 AM and 4:00 PM Monday – Friday.

Thank you for your cooperation,

The Sleep Team

Polysomnogram (Sleep Study)

Patient

Questionnaire

Patient Name:	ID Number:	Date Completed:
Height:	Weight:	

LIST ALL CURRENT MEDICATIONS INCLUDING VITAMINS AND HERBAL SUPPLMENTS

Have you recently started or stopped any prescribed medications? If so, state the name of the medication, if it was added or stopped, and the date you began or ended it.

PLEASE CHECK ANY OF THESE THAT APPLY:

☐ Snoring SN	☐ Snorting/Gasping SNT	☐ Fatigue FTG
☐ Excessive Daytime Sleepiness EDS	☐ Chronic Pain CP	☐ Stress STR
☐ Leg Jerking LJ	☐ Morning Headache MH	☐ Migraine MIG
☐ Loss of Muscle Tone LMT	☐ Acid Reflux / GERD ACR	☐ Teeth Grinding TGR
☐ Panic Attacks PA	☐ Depression DEP	☐ Anxiety ANX
☐ Difficulty Falling Asleep DSI	☐ Difficulty Staying Asleep DSM	☐ Acting Out Dreams RBD
☐ Hallucinations HLC	☐ Sleep Attacks SAT	☐ Sleep Talking SLT
☐ Sleep Walking SWK	☐ Sleep Eating SE	☐ Wake Up Too Early EAW
☐ Poor Memory PM	☐ Frequent Nocturnal Urination FNU	☐ Frequent Awakenings FAW
☐ Poor Concentration PC	☐ High Cholesterol HCH	☐ Night Sweats NST
☐ High Blood Pressure/Hypertension HYP	☐ Non-restorative Sleep NSR	☐ Legs Sore and Achy RLS
☐ Claustrophobia CL	☐ History of Seizures or Spells HXSZ	☐ Briefly Can't Move Upon Waking SP
☐ Heart Attack HXHA ☐ Stroke HXST	☐ Peripheral Vascular Disease PVD	☐ Legs Moving Restlessly RLSC

☐ Witnessed Breathing Issues During Sleep WA	Do you have any other medical conditions which we have not listed?
☐ Frequent Body Position Changes FBPOS ☐ Coronary Artery Disease CAD	
☐ Heart Failure HF ☐ Cardiovascular Disease CD ☐ Heart Problems HP	
☐ Diabetes? ___ Type: ____ Controlled? ___ DBT	

Polysomnogram (Sleep Study)

Patient

Questionnaire

SLEEP HABITS

Understanding your *normal* sleep habits is important in understanding more about your sleep or sleep problems.

Do you work swing shifts or night shifts? ☐ Yes ☐ No

What is your **normal** bed time? _____

- On average, how many minutes does it take you to fall asleep? _____
- Do you go to sleep with the television on? ☐ Yes ☐ No

What is your **normal** wake time? _____

- Do you frequently hit the snooze button in the morning? ☐ Yes ☐ No
- How long does it take you to wake up in the morning? _____

How **long** do you sleep on a **normal night**? _____

Do you fall asleep at work or school? ☐ Yes ☐ No

Have you ever fallen asleep while driving? ☐ Yes ☐ No

(Please remember, NEVER drive while drowsy/sleepy!)

What time did you go to bed **last night**? _____

What time did you wake up? _____

Approximately how many hours of **sleep** do you think you got last night compared to time spent in bed? _____

Over the past couple of weeks, how many hours per night did you sleep? _____

Do you use oxygen? ☐Yes ☐No

If yes, do you use oxygen: ☐ All the time. ☐ Night Time LPM: ____

Polysomnogram (Sleep Study)

Patient

Questionnaire

Do you currently wear Positive Airway Pressure therapy (CPAP, BIPAP, or Auto SV) while you sleep?

☐ Yes ☐ NO

If so, what is your current pressure setting? _____ cm H2O

Who is your Current Durable Medical Equipment (DME) Provider? _____

How many hours per night do you wear your CPAP/BIPAP/Auto SV? _____

How long have you been on positive airway pressure therapy? _____

Does anyone in your family have a known sleep disorder; tell us **which sleep disorder** and **how they are related** to you:

_____

PLEASE TELL US ABOUT YOUR DAY TODAY

HAVE YOU HAD ANY OF THE FOLLOWING TODAY? IF SO, WHEN AND HOW MUCH:

Caffeine:_____Alcohol:_____Nicotine:_____Other:_____

Do you use or have you used during **the past week**, any recreational street drugs?_____

Was your last meal heavy, or light? _____What time was that?_____

Was your day today unusually exciting or stressful? _____

If so, how? _____

Do you have any physical complaints at this time such as pain, cold/hot, aches, etc.?

Are you tired / sleepy now? _____ If not, why? _____

Do you have any additional comments or concerns?

Polysomnogram (Sleep Study)

Patient

Questionnaire

Epworth Sleepiness Scale

Please use the following scale, to decide the likeliness you would doze off or fall asleep in the following situations. Even if you have NOT done some of these things RECENTLY, try to answer how they would have affected you.

Using the following scale, Please choose the most appropriate number for each situation:

0 = Would **NEVER** doze or fall asleep, **1** = **Slight Chance** of dozing or falling asleep,
2 = **Moderate Chance** of dozing or falling asleep, **3** = **High Chance** of dozing or falling asleep

Situation:	Chance of Dozing:
Sitting and Reading	
Watching TV	
Sitting, Inactive in a public place (Theatre, meeting, etc.)	
As a passenger in a car, for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch, without alcohol	
In a car while stopped for a few minutes in traffic	
TOTAL SCORE	

Add up the numbers you put in each box to get your total score. A total score of less than 10 suggest that you may not be suffering from excessive daytime sleepiness. A total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive daytime sleepiness and whether you have an underlying sleep disorder.

It is important to remember that true excessive daytime sleepiness is almost always caused by an underlying medical condition that can be easily diagnosed and effectively treated.

PATIENT SIGNATURE: _____ Date: _____

SLEEP TECH SIGNATURE: _____ Date: _____

International Restless Leg Syndrome (IRLS) Symptoms Questionnaire

Name: _____ Patient ID Number: _____ Date: _____

1.) Do you have the desire to move your legs, often because of discomfort or restlessness?

(The need to move is often accompanied by uncomfortable sensations. Some words used to describe these sensations include: creeping, itching, pulling, creepy-crawly, tugging, or gnawing.)

☐ YES ☐ NO ☐ Not Applicable

2.) Does this desire occur or become worse when you are at rest, in other words, when you are sitting or lying down?

(The longer you are resting, the greater the chance the symptoms will occur and the more severe they are likely to be.)

☐ YES ☐ NO ☐ Not Applicable

3.) Do you note any relief of symptoms completely or partly during activity?

(The relief can be complete or only partial but generally starts very soon after starting an activity. Relief persists as long as the motor activity continues.)

☐ YES ☐ NO ☐ Not Applicable

4.) Do these symptoms occur or worsen only in the evening or at night?

(Activities that bother you at night do not bother you during the day.)

☐ YES ☐ NO ☐ Not Applicable

Patient / Legal Guardian Signature: _____ Date: _____

Technician Signature: _____ Date: _____