The Sleep Health Center

2608 Keiser Blvd.
Wyomissing, PA, 19610
Phone (610) 685-5864/Fax (610) 929-0859

Dear (Name) _____,

Thank you for choosing Respiratory Specialist's Sleep Health Center for your sleep services. Your study has been scheduled for (Day)_____ , (Date) _____.

Please arrive at 8:30 PM. The test will end at approximately 5:30 AM.

The Sleep Health Center is located in the lower level of the Respiratory Specialist professional building at 2608 Keiser Boulevard, Wyomissing, Pa. There is ample parking near the entrance. Please do not park in designated handicapped areas unless you have proper identification on your vehicle. Upon entering the foyer, please ring the bell on the left wall for the technician.

The test will end at approximately 5:30 AM the following morning. Each individual patient bedroom has a full or queen bed, private bath and shower, television and chair for your convenience. If you require an earlier wake time, please notify your technician.

Upon arriving at the Sleep health Center, your technician will show you to your room, explain the procedure and answer your questions. After you are settled in, several electrodes will be applied to monitor your vital signs including respiration, heart, muscle activity, oxygen saturation, and brain waves. You will then have time to relax until you are ready for bed. The technician will monitor you throughout the night. In the morning you will wake and have the opportunity to shower before returning home or going to work.

Your study will be scored by our staff and interpreted by one of our physicians. The ordering physician will receive the report and contact you with the results.

Typically, if these results show a positive study, you a CPAP Titration study will be ordered for you. This study is the same procedure as the initial study, with the addition of continuous positive airway pressure to treat and eliminate the episodes of sleep apnea that may be causing your symptoms. Your physician will discuss these results and treatment options with you.

Now that you know more about the study, you may be wondering how to prepare.

1. Please complete the enclosed forms (if you have not already completed them) and bring them with you on the night of the study.
2. Since the sensors are placed on the skin and scalp, we ask that you do not use hair spray or hair oils, lotions, powders or make-up.
3. No caffeine (coffee, tea, or soft drinks) after lunch on the day of the test.
4. Do not take naps the day of the study.
5. Do not stop any medication unless directed by your physician.
6. Please eat supper before coming for the test.
7. This is a Smoke Free building.
8. Friends or family members that accompany you here must leave before testing can start, unless approved by the staff.
9. Do not consume alcohol on the day of the study.

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10. Please bring these items with you
    a. Reading glasses, if needed
    b. Comfortable, loose fitting nightwear
    c. Any medications you need to take while here, such as insulin, syringes, inhalers, etc.
    d. List of current medications.
    e. Although we have pillows, you may wish to bring the pillow you usually sleep on.
    f. Health Insurance cards/ referral if indicated..
    g. The prescription for your study, referrals, etc.

IMPORTANT NOTES:

If you are going to be delayed for any reason, please contact us, 610-685-5864 Press #6. **Failure to communicate arrival delays by 9:15 P.M. may result in rescheduling of your appointment.**

* We require 48 hour notice for cancellation of this appointment except in cases of an emergency.

If you have any questions, please feel free to **call the Sleep Health Center** at **610-685-5864, ext 153.** We look forward to servicing your needs.

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Patient Name: _____ **Acct. #**_____ **Date:** _____

EPWORTH SLEEPINESS SCALE

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
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

Reference: Johns, M.W. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale. SLEEP. 1991; 14:540-5.

Name:_____

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Date	Did you use a sleeping pill, alcohol, or any medication to help you sleep?	What did you eat one hour before bedtime?	How concerned are your ability to sleep?	How many naps did you take today?	Have you had any coffee, cola, or chocolate since noon?	8pm	9pm	10pm	11pm	12am	1am	2am	3am	4am	5am	6am	7am	8am	9am	How many hours in bed?	Total hours of sleep.	Rate your quality of sleep. (1-3)	If you were awake, what did you do? (Watch TV, eat, worry, read??)
Example	No	Chips	2	1	No				↓	—	—	—	↑		↓	—	↑						

Two-Week Sleep Diary

1. Put down arrows at the times you went to bed and up arrows at the times you got up.
2. Draw a line through the times you were asleep.
3. When rating 1-3, 3 would be best or most.

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Name:_____ **Date:**_____

Part 1

In order to help diagnose and treat you, please take time to complete this questionaire prior to your appointment. Check the block that best applies to you and bring the completed form to the office.

	Always	Frequently	Occasionally	Never
I am told I snore				
I am told I stop breathing while I sleep.				
I wake up choking or gasping				
I fall asleep when I don't want to.				
I fall asleep when I am driving				
I have headaches in the morning.				
I take a nap every day.				
I frequently awaken with a dry mouth.				
I have difficulty concentrating.				
I wish I had more energy.				
I feel like I am going around in a daze.				
I feel sleepy during the day even though I slept through the night.				
I have trouble at work because of sleepiness.				
I sweat excessively at night.				
I feel my heart pounding during the night.				
I have high blood pressure.				
I have to get up to go to the bathroom more than once a night.				
I "wet" the bed.				
I drink at least three caffeinated beverage every day.				
I drink caffeinated beverages every evening.				
I am losing my sex drive.				
I feel muscle tension in my legs other than when I am exercising.				
I have been told that I kick at night.				
I have noticed that part of my body jerks at night.				
I have leg pain or cramps at night.				
I awaken with sore muscles.				
I experience vivid dream like scenes soon after falling asleep.				
I have episodes of feeling unable to move after falling asleep.				
I fall asleep at social settings like parties or restaurants.				
My muscles go limp when I laugh, get mad, or get startled.				
I find naps refreshing.				
I take longer than 30 minutes to fall asleep.				

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continued				
I often wake up during the night and have trouble falling back to sleep.				
I am sleepy before bed, but not when I go to bed.				
I have thoughts racing through my head when I try to go to sleep.				
I wake up for unknown reasons and I have trouble going back to sleep.				
I get frustrated and/or anxious when I can't fall asleep.				
I need medication or alcohol to help me sleep at night.				
Part 2				
Please answer the following questions:				
I usually go to bed at				
I usually wake at				
I work day shift, evening shift, night shift.				
Rotate shifts or not applicable				
My neck collar size is				
My highest weight in high school was				
My weight 5 years ago was				
My weight 1 year ago was				