

Serving Banner Health Community Hospital – 2000 Campbell Drive, Torrington Wyoming

*Hello!*

*We are looking forward to meeting you and performing your sleep study! Enclosed you will find a questionnaire, sleep diary and general instructions. We need you to bring this questionnaire and sleep diary with you the night of your sleep study at Community Hospital in Torrington. Please complete the medications list and bed partner questionnaire if applicable.*

*On the day of your study please refrain from taking a nap and do try your best to limit your caffeine intake. Also, please shower and wash your hair before coming. We will be placing six small sensors on your scalp and this helps us get the best readings possible.*

*If you have any questions please call our office in Scottsbluff Monday through Friday between the hours of 9:00 am to 4:00 pm. Our office telephone is (308)-633-3000. Pam or Mark will be happy to answer any questions you may have.*

*Thank you again for choosing Western Sleep Medicine at Community Hospital in Torrington. We look forward to serving You!*

*Western Sleep Medicine is staffed by Registered Polysomnographers, Registered Nurses, and a Registered Respiratory Therapist.*

# SLEEP STUDY INSTRUCTIONS

PATIENT NAME: \_\_\_\_\_

Your nighttime sleep study is scheduled for: \_\_\_\_\_

---

**It is very important for you to read the following information and complete the questionnaires before coming to the Sleep Lab**

## THINGS TO REMEMBER

- Day of study, **do not** take a nap, try to keep busy.
- Day of study, please limit your caffeine intake, also **no** consumption of caffeine products after 12 noon (coffee, sodas and chocolate).
- Arrive at BANNER COMMUNITY HOSPITAL, 2000 CAMPBELL DRIVE, TORRINGTON, WYOMING at \_\_\_\_\_ p.m. Please check in at the Emergency desk on the front side of the hospital (southeast corner).
- Please shower, wash your hair and refrain from using any hair care products. If you normally shave then please do so the day of your test.
- Please be aware that during your study you will not be allowed to have the following with you in your room; pagers, personal phones or watches as they interfere with the test results. If a phone or pager must be brought in with you, then the technician in charge of your testing will be more than happy to keep it in the observation room in case of emergencies.

## PLEASE BRING WITH YOU

- **Toiletry items:** Combs/hair brush, toothbrush/toothpaste.
- **Clothes:** Loose fitting nightclothes and a change of clothes for the next day.
- **Medications:** Any medication that is prescribed by your doctor, or over the counter medications you are currently taking and a current list of your medications.  
\*\*\*\*\*No Medication will be Administered by our Staff\*\*\*\*\*
- **Diabetic Supplies:** Please bring your glucometer and supplies.
- **Reading Material:** Something to help relax in your room before your test.
- **Questionnaire:** Please bring the completed questionnaire previously sent to you.

**If you become sick or cannot make your scheduled appointment, please call Kathy @ Community Hospital in Torrington (307)534-7216  
Before 1:00 p.m**

# PATIENT SLEEP STUDY INFORMATION

## What is a Polysomnogram?

A Polysomnogram is a procedure that reads and registers body functions during sleep. Some of these measurements include:

- **Brain waves** [Electrodes placed on patient's scalp]
- **Heart beats**
- **Eye Movements** [Electrodes placed by the patient's eyes]
- **Leg movements** [Electrodes placed on the patient's legs]
- **Airflow Breathing** [Sensor placed under the patient's nose]
- **Chest/Abdominal Breathing** [Sensors placed on the patient's chest and abdomen]
- **Blood Oxygen Levels** [Sensor attached to the patient's finger]

## Why Record This Information?

During sleep, the body functions differently than while awake. Recording these readings will help the doctors better diagnose and treat your sleep problem.

## How Can I Sleep With All Of These Things On Me?

Surprisingly, most people sleep reasonably well. The sensors are applied so that you can turn and move during sleep. Our staff will try to make your environment as comfortable as possible.

## Will The Sensor Devices Hurt?

No. Although sometimes in rubbing the skin or putting on the electrodes there will be mild and temporary discomfort and skin irritations.

## Will I Be Given A Drug To Help Me Sleep?

No, unless these have been prescribed by your doctor. **PLEASE, DO NOT STOP ANY OF YOUR MEDICATIONS WITHOUT FIRST CONSULTING YOUR PERSONAL PHYSICIAN!**

## What Should I Bring?

Your own pillow, bed clothes [Preferably two piece pajamas or gym shorts and T-shirt], and a book of something to work on while waiting. **Bring Your Prescribed Medications!**

## What Happens To The Polysomnogram?

Sleep studies are reviewed the following day by Mark Schultz, RPSGT and forwarded to Dr. Norman Imes, Clinical Professor of Medicine, OU Health Sciences Center and a Diplomate of the American Board of Internal Medicine, Sleep Medicine. Dr. Imes is licensed in Wyoming and recognized nationally as an expert in the field of sleep medicine. Generally, results will be returned to your physician within 3-5 working days of the date of your study. Your primary care physician will contact you for a follow up visit to review your results.

# **INSTRUCTIONS FOR COMPLETING QUESTIONNAIRES**

While an extensive sleep history will be taken by the Sleep Technician the night of your study, answering these questionnaires will aid in the diagnostic process. Enclosed are the following questionnaires:

**PLEASE USE BLUE OR BLACK INK**

1. **MEDICATIONS LIST**

- It is IMPORTANT that you provide the Sleep Technician with a complete list of your current medications with the dosage and daily intake clearly stated.

2. **SLEEP LOG/SLEEP HISTORY**

- Please begin this as soon as you receive the questionnaire packet.

3. **QUESTIONS ABOUT YOUR SLEEP AND WAKE BEHAVIOR**

- please be as thorough as possible

4. **BED PARTNER QUESTIONNAIRES**

- If you have a bed partner who has recently observed your sleep please have them complete this questionnaire.

5. **EPWORTH SLEEPINESS SCALE**

- This is a standard medical assessment that is scored by the registered sleep technologist and aids in your diagnosis.

**PLEASE BRING THESE COMPLETED QUESTIONNAIRES WITH YOU TO THE  
SLEEP LAB FOR EVALUATION  
THE NIGHT OF YOUR STUDY**

# EPWORTH SLEEPINESS SCALE

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_ AGE: \_\_\_\_\_

GENDER: (circle one) MALE FEMALE

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 off
- 1- slight chance of dozing
- 2- moderate chance of dozing
- 3- high chance of dozing

<u>SITUATION</u>	<u>CHANCE OF DOZING</u>			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g., a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour Without a break	0	1	2	3
Lying down to rest in the afternoon When permitted	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch with no alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

TOTAL SCORE: \_\_\_\_\_ AVG. AMOUNT(HOURS) OF SLEEP PER NIGHT \_\_\_\_\_

## PATIENT INFORMATION

PATIENTS NAME: \_\_\_\_\_

First Middle Last

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_-\_\_\_\_-\_\_\_\_

AGE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ SEX: FEMALE MALE

MARITAL STATUS (Please Circle One) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (Please Circle One) SELF SPOUSE CHILD OTHER

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

PATIENT'S EMPLOYER INFORMATION: \_\_\_\_\_ COMPANY: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ Ph. #: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

---

## RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESPONSIBLE PARTY NAME: \_\_\_\_\_

If Same as Above Please Write **Same** First Middle Last

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_ SEX: FEMALE MALE

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_-\_\_\_\_-\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

RESPONSIBLE PARTY'S EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

---

## INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

GROUP NAME: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_ CONTRACT (ID) NUMBER: \_\_\_\_\_

SUBSCRIBERS NAME: \_\_\_\_\_ SUBSCRIBER DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

PATIENT RELATIONSHIP TO SUBSCRIBER: Please Circle One SELF SPOUSE CHILD OTHER

---

SECONDARY INSURANCE COMPANY/ MEDICARE SUPPLEMENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

GROUP NAME: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_ CONTRACT (ID) NUMBER: \_\_\_\_\_

SUBSCRIBERS NAME: \_\_\_\_\_ SUBSCRIBER DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

PATIENT RELATIONSHIP TO SUBSCRIBER: Please Circle One SELF SPOUSE CHILD OTHER

# SLEEP QUESTIONNAIRE

PATIENTS NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

---

## **WHAT PROBLEMS DO YOU HAVE WITH SLEEP?**

*PLEASE CHECK ALL THAT APPLY*

Loud snoring	Tired/sleepy during the day	Sleep talking
Toss and turn in bed	Difficulty falling asleep	Sleep walking
Frequent awakenings	Legs movement at night	Act out dreams
Shallow breathing at night	Legs uncomfortable at night	Teeth grinding
Stop breathing during sleep	Muscle cramps at night	Bed-wetting

### **CIRCLE LEVEL OF SNORING:**

0 1 2 3 4 5 6 7 8 9 10

Circle position(s) of sleep snoring is heard:      Left side      Right side      Back      Stomach

How many years has snoring occurred? \_\_\_\_\_ Worsened over how long? \_\_\_\_\_

How many nights a week, on average, are you disturbed by poor sleep? \_\_\_\_\_

Has snoring caused you or bed partner to move to another room?      YES / NO

Has your own snoring awakened you from sleep?      YES / NO

Have you had any facial injury or a broken nose?      YES / NO

Have you undergone any nose or throat surgery, including tonsillectomy?      YES / NO

Do you awaken with a headache?      YES / NO

Has anyone noticed periods where you stop breathing at night?      YES / NO

### **SLEEP HABITS**

What time do you usually get into bed at night? \_\_\_\_\_

How long does it take you to fall asleep? \_\_\_\_\_

How many times do you awaken at night? \_\_\_\_\_ Why? \_\_\_\_\_

What time do you get up in the morning? \_\_\_\_\_

Do you feel refreshed or still tired? Comments: \_\_\_\_\_

Rate your level of energy during the day. (poor) 0 1 2 3 4 5 6 7 8 9 10 (excellent)

Do you take naps? YES / NO

Do you feel refreshed after a nap? YES / NO

Do you ever doze or nod off if you sit for awhile? YES / NO

Are you a shift worker? YES/NO      If so, what shift? \_\_\_\_\_

### **LEG MOVEMENT**

I have an aching or crawling sensation in my legs in the evening.      YES / NO

I cannot keep my legs still in the evening      YES / NO

I have an unpleasant sensation in my legs that improves with activity  
and gets worse with rest or inactivity.      YES / NO

### **OTHER QUESTIONS**

How much caffeine do you consume during each day? \_\_\_\_\_ Coffee: \_\_\_\_\_ Cola/tea/etc. \_\_\_\_\_

Do you drink alcohol before bedtime? (kind and number of drinks) \_\_\_\_\_

Sudden weakness with strong emotion (anger or laughter) YES / NO

Indigestion / heartburn during sleep? YES / NO

Paralysis on waking or falling asleep? YES / NO

Hallucination on waking or falling asleep? YES / No



# **BED PARTNER QUESTIONNAIRE**

NAME OF PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME OF PERSON FILLING OUT FORM: \_\_\_\_\_

I HAVE OBSERVED THIS PERSON SLEEP:  
ONCE OR TWICE                      FREQUENTLY                      EVERY NIGHT

PLEASE CHECK ANY OF THE FOLLOWING BEHAVIORS OBSERVED WHILE THIS PERSON WAS SLEEPING

- |                   |                 |                             |            |
|-------------------|-----------------|-----------------------------|------------|
| Light Snoring     | Loud snoring    | Occasional loud snorts      | Choking    |
| Grinding Teeth    | Leg Movement    | Pauses in Breathing         | Crying Out |
| Awakening in Pain | Becoming ridged | Sitting up in bed not awake |            |

Other: \_\_\_\_\_

Please describe any additional comments you have about the sleep disorders above. Might want to include activity, the time during the night in which it happens, frequency during the night, and whether it occurs every night.

---

---

---

---

---

---

---

---

---

---

Has this person ever fallen asleep during normal daytime activities or in potentially dangerous situations?  
Yes                      No

If yes, please explain:

---

---

---

---

---

---

---

Revised 06-01-10

<b>SLEEP DIARY</b>		
NAME _____	START DATE _____	COMPLETION DATE _____

*Please darken the times with pen that you are asleep during the daytime and/or nighttime*

Date	Day	6am	7am	8am	9am	10am	11am	noon	1pm	2pm	3pm	4pm	5pm
	1												
	2												
	3												
	4												
	5												
	6												
	7												
	8												
	9												
	10												
	11												
	12												
	13												
	14												

Date	Day	6pm	7pm	8pm	9pm	10pm	11pm	mid-night	1am	2am	3am	4am	5am
	1												
	2												
	3												
	4												
	5												
	6												
	7												
	8												
	9												
	10												
	11												
	12												
	13												
	14												

If sleeping medications were taken, please make note of the medication, and star the date/time that these medications were taken.

\_\_\_\_\_