Scheduled Appointment Information

Your physician ordered sleep study has been scheduled as follows:

Date and Time: _____ AT _____PM

Location: 430 N. Monte Vista, Ada, Oklahoma.

Please arrive at **8:30 pm at Valley View Regional Hospital through the Main Lobby Registration** desk. After you are checked in, the sleep technician will escort you to the sleep lab.

- **Due to the increased volume of patients if you arrive more than 15 minutes after your scheduled time, the appointment may be given to someone else. If you are running late the night of your study, please contact a technician at 580-272-1717 to hold your spot.**

*** Reminder:** No nap or caffeine after 4 pm the day of your study. Please eat your evening meal at least 2hours prior to your scheduled test time. Do not consume any Alcohol 24hours prior to the test

*** IMPORTANT: You must cancel or reschedule 24 hours before your set appointment or you will be charged a technician fee of $250.00. To receive a refund of the fee, all appointments must be rescheduled within 72 hours of the original scheduled appointment and you must attend the newly scheduled appointment.**

Things to bring with you:

1. The enclosed questionnaire – (please complete prior to arrival)
2. Something loose fitting and comfortable to sleep in, as well as, a robe and slippers.
3. All medications that you are currently taking - (please have them written down prior to arrival)
4. Your insurance card and two forms of identification including a picture I.D.

Things to remember:

1. Questions regarding your medications should be referred to your physician.
2. Your hair **must** be clean and free of gels and hair spray materials.
3. We have pillows; however, please feel free to bring your own to add to your comfort.
4. Bring an overnight bag with the items you would normally use for an overnight stay.
5. Smoking materials, tobacco, and firearms are prohibited in our facility.
6. Please complete all smoking prior to coming up to the sleep disorders center.
7. You should contact our office, and speak directly to our staff, if you have any of the following on the day you are scheduled for your sleep study: Flu, diarrhea, fever, severe nasal congestion, or migraine headache. If you feel you need to reschedule your sleep study, please contact our staff at **405-949-0060** or **866-748-4350.**

Insurance & Financial Information:

If you have any questions regarding your financial responsibility please feel free to call Valley View Regional Hospital at **580-272-1791.** You will be responsible for the actual contracted amount if the claim is not paid in full. We urge you to contact your insurance provider member services to verify the information above.

Our patient care coordinator will be happy to answer any questions you may have (866)748-4350 M-F 8-5.

Information on Sleep Disorders

Are you getting a good night's sleep? Sleep disorders cause more than just sleepiness – a lack of restorative rest can cause accidents on the job and on the road; affect your relationships, health, and mental capability; and make you feel generally "disconnected" to the world around you. .

Sleep disorder symptoms

Getting a good night's sleep is essential for feeling refreshed and alert during the day. Sleep disorders left untreated can even be hazardous to your health. Luckily, through proper testing, diagnosis and care, sleep disorders can be managed and overcome.

Particular behaviors during normal daytime activities are telltale signs of sleep deprivation. If you are experiencing one or more of the following symptoms during the day, you may not be getting enough restful sleep at night, and you may even have a sleep disorder.

Do you . . .

- feel irritable or sleepy during the day?
- have difficulty staying awake when sitting still, such as when watching television or reading?
- fall asleep sometimes while driving?
- have difficulty paying attention or concentrating at work, school, or home?
- perform below your potential in work, school, or sports?
- often get told by others that you look tired?
- have difficulty with your memory?
- react slowly?
- have emotional outbursts?
- feel like taking a nap almost every day?
- require caffeinated beverages to keep yourself going?

Common types of sleep disorders

In order to get a proper diagnosis, it's important to understand the symptoms and causes of the most common forms of sleep problems - **Sleep Apnea, Insomnia, RLS, and Narcolepsy.**

Sleep Apnea Sleep Disorder

Sleep apnea is a common disorder that can be very serious, and even life-threatening. In sleep apnea, your breathing stops or gets very shallow while you are sleeping. Each pause in breathing typically lasts 10 to 20 seconds or more. These pauses can occur 20 to 30 times or more an hour.

The most common type of sleep apnea is **obstructive sleep apnea.** During sleep, enough air cannot flow into your lungs through your mouth and nose, even though you try to breathe. When this happens, the amount of oxygen in your blood may drop. Normal breaths then start again with a loud snort or choking sound.

Symptoms can be quite scary - frequent waking episodes at night, usually accompanied by a feeling of "choking" or gasping for air. Significant others or roommates of those with sleep apnea often report hearing gasping, gagging, or choking sounds from their partners. The severity of this disorder makes treatment essential. Treatment may include behavioral changes, a CPAP/BiPap machine, and in some cases, surgery.

Insomnia

Insomnia is a significant lack of high-quality sleep. It can be short-term or chronic. Insomnia may be caused by stress, a change in time zones or sleep schedule, poor bedtime habits, or an underlying medical or psychiatric condition.

Symptoms include:

- Difficulty falling asleep despite being tired
- Requiring sleeping pills or alcohol to fall asleep
- Awakening frequently during the night or lying awake in the middle of the night
- Awakening too early in the morning despite not feeling refreshed
- Daytime drowsiness, fatigue, and irritability

Restless Legs Syndrome (RLS)

Restless legs syndrome (RLS) is a sensory disorder causing an almost irresistible urge to move the legs. The urge to move the legs is usually due to uncomfortable, tingly, or creeping sensations that occur when at rest. Movement eases the feelings, but only for a while. You may also notice small, jerky movements of the toes, feet, and legs as you are trying to fall asleep.

Narcolepsy

Narcolepsy is a disorder that causes a person to have difficulty staying awake. Narcolepsy can cause a person to suddenly fall asleep during the day. These “sleep attacks” occur even after getting enough sleep at night. The unusual sleep pattern that people with narcolepsy have can affect their schooling, work, and social life.
Falling asleep during activities like walking, driving, cooking, or talking can have dangerous results, both professionally and personally.

Symptoms include:

- Intermittent, uncontrollable episodes of falling asleep during the daytime
- Excessive daytime sleepiness
- Sudden, short-lived loss of muscle control during emotional situations (cataplexy)

Common tests for diagnosing sleep disorders

Epworth Sleepiness Scale- This sleep questionnaire asks you to rank whether certain situations make you sleepy and, if so, how sleepy.

Overnight sleep study- is a test that measures the electrical activity of your brain (electroencephalogram) and heart (electrocardiogram), and the movement of your muscles (electromyogram) and eyes (electro-oculogram), and usually requires an overnight stay at a sleep clinic for observation purposes.

Once you arrive to our facility, a team of sleep specialists will use the latest technology to monitor you while you sleep. You will be given a private room, where a technician will attach a variety of monitoring devices to your body once you are ready for bed. A sleep specialist will observe your sleep patterns using these devices, which monitor brain waves, heart rate, rapid eye movements, and more.

The next morning, the technician will remove all the monitoring devices, and you will be able to go straight to work or on to your daily activities. The sleep specialists will analyze the results from your sleep study and send your referring physician the results where he/she will go over and design a treatment program if necessary. If treatment of sleep apnea is necessary, you will be sent to a DME company for CPAP setup.

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SLEEP STUDY MEDICAL HISTORY

Patient Name: _____

Height: _____ Weight: _____ Age: _____

Symptoms of Sleep Disturbances: (check those that apply)

☐ Witnessed apnea	☐ Shortness of breath	☐ Sleep-Walking	☐ Chronic fatigue
☐ Post UPP	☐ Nightmares	☐ Asthma	☐ Narcolepsy
☐ Snoring	☐ Obesity	☐ Elongated palate	☐ Cataplexy
☐ Restless legs	☐ Bedwetting	☐ Excessive sleepiness	☐ Insomnia
☐ Nocturnal choking	☐ Nasal obstruction	☐ p.m. alcohol	☐ Claustrophobia
☐ Leg/body jerks	☐ Sleep terrors	☐ Chronic Pain	
☐ Fitful sleep	☐ GI reflux/heartburn	☐ Periodic leg movement	
☐ REM Behavior	☐ Sleep attacks	☐ Violent activity during sleep	
☐ Depression	☐ Frequent awakenings		

Pertinent Medical History: (check those that apply)

☐ High Blood pressure	☐ Head injury	☐ Heart attack
☐ COPD/Emphysema	☐ Neuromuscular disease	☐ Memory loss
☐ s/p stroke	☐ Seizures	☐ Neuromuscular Disease
☐ Cardiovascular disease	☐ Premature birth	☐ Parkinson's Disease
☐ Diabetes	☐ Thyroid disease	☐ Mood disorder
☐ Kidney failure	☐ Broken nose	☐ Fibromyalgia
☐ Cerebral Palsy	☐ Oxygen: LPM____	☐ Other:_____
☐ Head injury	☐ History of Motor Vehicle Accident	

Surgeries: (check those that apply)

☐tonsils ☐adenoids ☐UPPP ☐deviated septum ☐nasal polyp ☐laser
☐tracheotomy ☐upper or lower ☐jaw reconstruction

Previous Sleep Study:

☐No ☐Yes When and where:_____
(If previous sleep study, please include a copy of this report.)

Current Treatment of Sleep Apnea:

☐CPAP Pressure_____ ☐ Bi-Level Pressure_____ ☐Oxygen Liters_____

Medications:_____

_____

_____

*Revised 7/12/2011

SLEEP QUESTIONNAIRE

Patient ID: _____ Date of Study: _____

NAME: _____ AGE: _____ SEX: _____ Date:_____

REFERRING PHYSICIAN: _____

HT: _____ WT: _____ Neck Size: _____

PLEASE GIVE THE COMPLETED QUESTIONNAIRE TO THE TECHNICIAN AT THE TIME OF YOUR SLEEP STUDY.

MY PRIMARY SLEEP COMPLAINT IS: _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

HAVE YOU EVER SEEN A PHYSICIAN FOR THIS PROBLEM? _____

HAVE YOU EVER HAD A SLEEP STUDY? _____

(IF YES, WHEN AND WHERE) _____

DO YOU HAVE ANY OTHER SLEEP PROBLEMS? _____

(IF YES, PLEASE DESCRIBE) _____

DO ANY OF YOUR FAMILY MEMBERS HAVE A SLEEP DISORDER? (IF YES, DESCRIBE)
_____

DO YOU USE OXYGEN AT HOME? NO ___ YES ___ 24 HR/DAY ___ NIGHT ONLY ___

MEDICATION NAME	DOSAGE	REASON

****USE THE OTHER SIDE OF THIS PAGE TO LIST ADDITIONAL MEDICATIONS.

LIST YOU INTAKE PER DAY OF THE FOLLOWING:

ITEM	DAILY INTAKE	ITEM	DAILY INTAKE	ITEM	DAILY INTAKE
COFFEE		BEER		CIGARETTES	
CAFFIENE SODA		WINE		CIGARS/PIPE	
TEA		LIQUOR		SNUFF	

WHAT TIME DO YOU GO TO SLEEP? _____WHAT TIME DO YOU WAKE UP?_____

HOW LONG DOES IT USUALLY TAKE YOU TO FALL ASLEEP?_____

DO YOU AWAKEN OFTEN DURING THE NIGHT? _____

(IF YES, WHY?) _____

DO YOU NAP DURING THE DAY? _____

(IF YES, DO YOU FEEL REFRESHED UPON AWAKENING?) _____

DO YOU WORK DIFFERENT SHIFTS? _____

(IF YES, WHAT SHIFT(S) DO YOU WORK?) _____

Name: _____ Date of Study: _____

Patient ID: _____

Please answer the following questions using this scale: (Consult bed partner)

0=never 1=rarely 2=sometime 3=often 4=frequently 5=always

EXCESSIVE DAYTIME SLEEPINESS:

0 1 2 3 4 5 I FEEL SLEEPY DURING THE DAY.

0 1 2 3 4 5 I SOMETIMES FALL ASLEEP WHEN I DON'T WANT TO.

0 1 2 3 4 5 I FALL ASLEEP WHEN I READ THE NEWSPAPER.

0 1 2 3 4 5 I FALL ASLEEP WHILE WATCHING TV.

0 1 2 3 4 5 I FALL ASLEEP AT WORK.

0 1 2 3 4 5 I FALL ASLEEP AT MEETINGS.

0 1 2 3 4 5 I HAVE FALLEN ASLEEP WHILE DRIVING.

0 1 2 3 4 5 I GET SLEEPY WHILE DRIVING.

0 1 2 3 4 5 I HAVE PROBLEMS WITH MY PERFORMANCE AT WORK BECAUSE OF FATIGUE AND TIREDNESS.

0 1 2 3 4 5 I DON'T FEEL REFRESHED WHEN I AWAKEN.

0 1 2 3 4 5 I HAVE TO TAKE NAPS DURING THE DAY.

0 1 2 3 4 5 I GET SLEEPY WHEN I AM INACTIVE.

0 1 2 3 4 5 I HAVE TO PUSH MYSELF TO GET THINGS DONE.

0 1 2 3 4 5 I HAD TROUBLE STAYING AWAKE DURING THE DAY AS A CHILD.

SLEEP APNEA:

0 1 2 3 4 5 I HAVE BEEN TOLD THAT I SNORE.

0 1 2 3 4 5 OTHERS CAN'T SLEEP IN THE SAME ROOM BECAUSE I SNORE.

0 1 2 3 4 5 I HAVE BEEN TOLD I STOP BREATHING WHILE ASLEEP.

0 1 2 3 4 5 I AWAKEN WITH HEADACHES.

0 1 2 3 4 5 I AM OVERWEIGHT OR AM GAINING WEIGHT.

0 1 2 3 4 5 I PERSPIRE AT NIGHT.

0 1 2 3 4 5 I HAVE BEEN TOLD I'M A RESTLESS SLEEPER.

0 1 2 3 4 5 I HAVE AWAKENED DURING THE NIGHT CHOKING.

0 1 2 3 4 5 I FEEL SLEEPY DURING THE DAY EVEN THOUGH I SLEPT ALL NIGHT.

0 1 2 3 4 5 I HAVE ASTHMA ATTACKS DURING SLEEP.

Name: _____ Date of Study: _____

Patient ID: _____

RESTLESS LEG SYNDROME OR NOCTURNAL MYOCLONUS:

0 1 2 3 4 5 I HAVE MUSCLE TENSION IN MY LEGS EVEN WHEN I'M RELAXED.

0 1 2 3 4 5 I HAVE BEEN TOLD PARTS OF MY BODY "JERK" AT NIGHT.

0 1 2 3 4 5 I HAVE BEEN TOLD I KICK DURING THE NIGHT.

0 1 2 3 4 5 I HAVE ACHING OR "CRAWLING" SENSATIONS IN MY LEGS.

0 1 2 3 4 5 I EXPERIENCE LEG PAIN DURING THE NIGHT.

0 1 2 3 4 5 SOMETIMES I CAN'T KEEP MY LEGS STILL AT NIGHT.

INSOMNIA:

0 1 2 3 4 5 I HAVE TROUBLE GETTING TO SLEEP AT NIGHT.

0 1 2 3 4 5 I HAVE TROUBLE STAYING ASLEEP AT NIGHT.

0 1 2 3 4 5 I AWAKEN IN THE MORNING LONG BEFORE I WANT TO.

0 1 2 3 4 5 I WORRY I WILL BE UNABLE TO SLEEP.

0 1 2 3 4 5 I AWAKEN WITH FEELINGS OF ANXIETY OR FEAR.

SLEEP BEHAVIOR:

0 1 2 3 4 5 I HAVE BEEN TOLD I WALK IN MY SLEEP.

0 1 2 3 4 5 I HAVE BEEN TOLD I TALK IN MY SLEEP.

0 1 2 3 4 5 AS AN ADULT, I HAVE WET THE BED.

0 1 2 3 4 5 WHEN I LAUGH OR GET ANGRY, I FEEL LIKE I'M GOING LIMP.

0 1 2 3 4 5 I HAVE FALLEN ASLEEP WHILE LAUGHING OR CRYING.

0 1 2 3 4 5 I HAVE VIVID DREAM-LIKE SCENES UPON FALLING ASLEEP.

0 1 2 3 4 5 I FEEL LIKE I WALK AROUND IN A DAZE.

0 1 2 3 4 5 SOMETIME I CAN'T TELL DREAMS FROM REALITY.

0 1 2 3 4 5 I AWAKEN DURING THE NIGHT WITH HEARTBURN.

0 1 2 3 4 5 I HAVE BEEN TOLD THAT I ACT OUT MY DREAMS.

0 1 2 3 4 5 I HAVE NOW OR IN THE PAST HAD SEIZURES IN MY SLEEP. WHEN _____

LIST ANY PAST/PRESENT MEDICAL OR PSYCHAITRIC PROBLEMS. LIST ANY OTHER CONCERNS YOU HAVE ABOUT YOUR SLEEP.

_____

_____

_____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

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Epworth Sleepiness Scale

Patient: _____ Date: _____

The instrument

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 = no chance of dozing
- 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 (ie. a theater or a 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 traffic	
Total	

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Patient Information:

Patient Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Ht_____ LBS_____ Referring Physician_____

Primary Care Physician_____ Phone Number _____

SS#: _____ Gender: ☐ Male ☐ Female
Marital Status ☐S ☐M ☐D ☐W

Email address: _____

Insurance Information: **Please provide our office with a copy of your insurance card.**

Primary Insurance Carrier:_____ Phone: _____

ID #: _____Policy Group #: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Secondary Insurance Carrier:_____ Phone: _____

ID #: _____Policy Group #: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Employment Information:

Employer_____ Work Ph#: _____

If the patient is a minor, please list guardian information:

Guardian: _____ Phone #: _____

Third Party Billing:

Is your injury work related? ☐**Yes** ☐**No**

Is this injury due to an accident? ☐**Yes** ☐**No**

If your injury is MVA related, have you obtained an accident report? ☐**Yes** ☐**No**

Injury date or Date of Occurrence:_____.

Emergency Contact:

Name: _____ Relationship: _____
Phone: _____

☐ I would like to receive a copy of my final study mailed to my address provided.

Signature: _____ Date: _____

Revised 7/12/11