Dear Sleep Patient,

In order to provide you with the best possible service:

1. Please read the patient instructions attached. If you have any further questions, do not hesitate to contact us at (352)795-1999.

2. Please fill out the enclosed questionnaire and return it to the sleep technician the night of your study.
   Your study is scheduled for _____ at 8:30 PM.

3. On arrival, please go to the rear of the facility and knock on the door that says “Sleep Disorders Center”. For your safety and the safety of the technician, the door is kept locked at all times.

IMPORTANT

DUE TO OUR LONG WAITING LIST, IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT PLEASE CALL (352) 795-1999 **AS SOON AS POSSIBLE** SO THAT WE MAY ACCOMMODATE ANOTHER PATIENT IN YOUR ABSENCE.

We will gladly reschedule your appointment to a more convenient date.

A Sleep Center staff member will call to confirm your appointment a few days in advance. In the event of an **emergency after 7:30PM**, please call (352) 795-6076. If you do not receive an answer please let it ring or call back immediately in the event the technician is busy and unable to answer the phone.

PLEASE NOTE THAT THIS PACKET IS **FRONT AND BACK!!!**
THANK YOU FOR YOUR COOPERATION AND WE WILL SEE YOU SOON!!!!!!

A Comprehensive Sleep Disorder Center

Relief for your sleep disorder can be found at Citrus Pulmonary Consultants and Sleep Disorder Center. This center is one of the most comprehensive facilities in Citrus County which provides physician evaluations, state of the art diagnostic testing, and treatment for all sleep related disorders.

There are a wide variety of sleep disorders such as:

1. **Breathing problems**: Sleep apnea is a condition which you stop or have shallow breathing in your sleep. This condition is usually associated with loud snoring and daytime sleepiness. If left untreated, sleep apnea may cause increased high blood pressure and even mortality.
2. **Neurological problems**: Narcolepsy is a condition that causes sudden uncontrollable daytime sleepiness, vivid dreaming and “sleep attacks”, a loss of muscle control and sometimes hallucinations.
3. **Insomnia**: The inability to initiate and or maintain sleep. Often this may be due to emotional or situational circumstances, but if it lasts more than a few weeks, you may have a more serious problem.

These are just a few of the 84 known sleep disorders.

Medical Expertise

The Sleep Disorders Center at Citrus Pulmonary Consultants is one of the few Citrus County centers to have multiple board certified sleep disorder physicians certified by the American Board of Sleep Medicine to personally conduct your evaluation, diagnosis, and treatment. The technical staff is board certified by the Board of Registered Polysomnographic Technologists.

Sleep Testing (Polysomnography)

Polysomnography or "sleep study" is a test performed on patients that are suspected to have a sleeping disorder. This procedure is performed as an outpatient and is non-invasive. The procedure consists of a certified or highly trained technologist applying a series of electrodes and monitoring devices to the surface of the patient's head and body. The application of these monitoring devices causes no discomfort to the patient. Testing is done in a private bedroom, with a technologist monitoring your sleep patterns in a separate control area adjacent to your private room. The technologist is present for the entire study to make sure you are comfortable, safe, and to provide your physician with an excellent recording. This procedure is done at night between the hours of 8:30PM-6:00AM. At the conclusion of the test, you will be free to go about your normal activities.

Treatment and Follow Up

After your sleep study, please allow 7-10 business days for the results. If you are an established patient to Citrus Pulmonary Consultants and Sleep Disorders Center, you should have an appointment within two weeks to receive your results. If you are referred patient, your test results will be sent to your referring physician to share the results with you.

Once an accurate diagnosis has been made, treatment may begin. Depending on the diagnosis, treatment may include a need for medication or a change form current medication, medical equipment for use at home such as a CPAP or BiPAP, possible psychological counseling, or, in very rare cases, surgery may be recommended.

Some Tips to a Better Nights Sleep

1. Use the bedroom only for sleep.
2. Avoid caffeine and alcoholic beverages 4-6 hours before bed.
3. Avoid strenuous exercise 4-6 hours prior to bed.
4. Minimize light, noise, and extreme temperatures in the bedroom.
5. Avoid large meals at bedtime. A light snack may help promote sound sleep.
6. Maintain a regular wake time each day.
7. Try to go to bed only when drowsy. If unable to initiate sleep after about 20 minutes get up and do something light until drowsy, then go back to bed.
8. Avoid napping during the day.

Important Reminders For the Day of Your Sleep Study

1. Eat a normal dinner at your normal time.
2. Take your normal medications (including insulin) as prescribed by your physician, unless specifically directed not to by your physician. If you take a sleeping medication please bring it with you. Do not take it prior to arrival.
3. All patients must take a shower and thoroughly clean their skin and scalp. Please do not apply make-up, creams, gels, oils, or lotions of any kind after showering. This will allow the monitoring devices to stick better during your study. You may wear deodorant.
4. All patients must bring or wear a two piece outfit to sleep in. (For example: boxers and a t-shirt). This will allow the technologist to apply the electrodes effectively and still maintain your privacy.
5. Relax!!!
6. Patients will have the ability to make outgoing calls during the night if necessary. In the event of a TRUE emergency, and you need to be contacted in the middle of the night; the number you will be able to be reached at will be (352) 795-6076.
7. Please bring your questionnaire completely filled out prior to coming into the sleep center. This will enable the technologist to review your medications and medical history while you change into your sleepwear.
8. Due to the type of test you will be having, spouses or partners are not allowed to stay overnight during the testing process unless approved by the Medical Director of our center ahead of time. You may bring in your spouse or partner at the beginning of the night to help you get settled in and meet the technologist.
9. Try not to nap during the day of your study.
10. Patients may bring in something to eat or drink throughout the night if they wish. There is a refrigerator and microwave available. At this time, no drinks or snacks will be provided.
11. Please bring in any toiletry items you wish to use as we do not provide them. There is a restroom available, but we are not equipped with showers at this time.

WE CAN NOT WAIT TO HELP YOU GET A BETTER NIGHTS REST!!!!!!!!!!

SLEEP WELL

Sleep Questionnaire

DATE:_____

NAME:_____ DOB:_____
MARITAL STATUS:_____ AGE:_____

ADDRESS: _____
CITY:_____ZIP:_____
CONTACT PHONE NUMBERS:
HOME:_____ WORK:_____
CELL:_____

OCCUPATION:_____EMPLOYER:_____

REFERRING PHYSICIAN:_____
REASON YOU HAVE BEEN REFERRED FOR A SLEEP STUDY:_____
_____

MEDICATIONS

DO YOU TAKE ANY MEDICATIONS? If so please list ALL over the counter and prescribed medications!

Medication	Dosage	Frequency	Duration
1.			
2.			
3.			
4.			
5.			

IF YOU TAKE MORE MEDICATION THAN SPACE PROVIDED, PLEASE ATTACH A LIST.

For each of the following beverages listed below please give the average daily amount that you drink each day. Please keep in mind that most glasses used in the home setting are larger than 8 ozs.

	Cups per day
Caffeinated Coffee	_____
Decaffeinated Coffee	_____
Hot or Iced Tea	_____
Soft drinks	_____

On average how many alcoholic beverages do you drink? Again keep in mind the size of cans and glasses.

Weekdays: _____ drinks per day What kind:_____
Weekends:_____ drinks per day What kind:_____

Do you smoke? YES / NO If so, how long have you been smoking?_____
What do you smoke?_____ How much?_____ per day

Please list your normal sleep schedule below.

What time do you **go to bed** on **weekdays**? _____
What time do you **wake up** on **weekdays**? _____

What time do you **go to bed** on **weekends**? _____
What time do you **wake up** on **weekends**? _____

Do you sleep alone? YES / NO **Do you have a regular sleep partner? YES / NO**

Do you require separate rooms from your spouse or partner? YES / NO
If yes please explain**:**_____

The following questions will require a yes or no answer as well as an explanation.

1. **Do you have trouble falling asleep at night? _____**
   How long does it take on average? _____
2. **Do you wake up frequently at night? _____**
   How many times do you awake per night? _____
3. **Do you get up to go to the restroom?____** How many times?_____
4. **Have you been told that you snore?_____** Loudly?_____
5. **Do you experience difficulty breathing at night? _____**
6. **Do you ever wet the bed? _____** How often? _____

7. **How many pillows do you normally sleep with?_____**
8. **Do you awaken gasping or choking? _____**
9. **Do you awaken with coughing spells? _____**
10. **Do you wake up in the morning feeling tired/unrefreshed? _____**
11. **Do you wake up in the morning with a headache? _____**
    How many times per week**?**_____
12. **Do you wake up feeling disoriented/foggy?_____**
13. **Are you bothered by sleepiness during the day?_____**
14. **Do you fall asleep at inappropriate times? _____**
    When? (EX: watching TV, reading, work, talking with people, driving**)**_____
15. **Have you ever had an accident while driving due to falling asleep?**_____
16. **Have you gained weight recently?_____** How much**?**_____
    Over what period of time**?**_____
17. **Have you lost weight recently?_____** How much?____
    Over what period of time?_____ Was it intentional?_____
18. **Have you noticed yourself becoming increasingly irritable or short tempered recently?_____**
19. **Do you ever find yourself somewhere and you do not know how you to there?**_____
20. **Do you experience cramping, jerking movements, or uncomfortable sensations in your legs?_____** If so when? (while falling asleep, waking up, during the day) _____
    _____
21. **When you laugh or get angry, do you experience increased weakness or feel as though you might collapse? _____**
22. **Have you suddenly fallen for no apparent reason? _____**
23. **Do you ever experience sudden body weakness? _____**
    If so, are you aware of your surroundings at these times**?**_____
24. **Do you sleepwalk? _____**
25. **Do you talk in your sleep? _____**
26. **Do you grind your teeth when you sleep? _____**
27. **Do you ever wake up screaming? _____**
28. **Are you currently prescribed Oxygen to use?_____**
    If so, what is your current settings**?**_____
29. **Have you ever experienced seeing things or hearing voices that were not real? _____ If so, when? (ex: while falling asleep, during the night, upon wakening or during the day)**_____
    _____
30. **Did you fall asleep while answering these questions?**_____

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? (This is does not mean just feeling tired.) This pertains to your usual daily life recently. Even if you have not done some of these things please try to choose how they would affect you. Use the following scale for the most appropriate response for each situation.

0- You would never doze off.
1- Slight chance of dozing off.
2- Moderate chance that you will doze.
3- High chance of you dozing.

1. **While sitting and reading: _____**
2. **While watching television: _____**
3. **Sitting inactive in a public place: _____**
4. **Riding in a car for an hour without a break: _____**
5. **Laying down to rest in the afternoon: _____**
6. **Sitting and talking to someone: _____**
7. **Sitting quietly after lunch (without any alcohol): _____**
8. **Stopped in traffic for a few minutes (as the driver): _____**

Total:_____

Please add any comments that you feel are important to the technologist or the doctor to review!

_____
_____
_____
_____
_____
_____
_____

THANK YOU FOR FILLING OUT OUR QUESTIONNAIRE!!! THIS WILL HELP US WITH YOUR SLEEP DISORDER EVALUATION!

NAME: _____ DATE:_____

You have been diagnosed with possible sleep apnea; this condition may adversely affect your driving. People with sleep apnea often are three to four times more likely to have a motor vehicle crash or other accidents. These accidents may cause serious injury or death to you or others.

If you have had an accident or frequent near accidents due to sleepiness or inattention you should stop driving and operating dangerous machinery until your sleep disorder has been treated and you are no longer sleepy or inattentive while driving.

It is your responsibility not to drive if you are inattentive. If you drive or fly professionally, you must report your sleep disorder to the doctor who certifies that you are fit for your profession.

Sleep apnea, if present, is a treatable condition. Potential consequences of not being treated can include but are not limited to increased risk of stroke, heart disease, high blood pressure, diabetes and motor vehicle accidents. Therefore, your physician has advised you to get a sleep study and proper follow up treatment. Failure to comply is against medical advice with possible adverse consequences.

Please sign below that you understand the above statements. Thank you!

Patient Signature: _____ Date:_____