To prepare for your sleep study, please review this informational sheet and complete enclosed questionnaires. Bring the completed forms with you on the night of your study. Thank you.

Scheduling: Your health care provider has referred you for a sleep study. Please call Patient Scheduling to schedule your study appointment, if you have not already done so, toll free **1-877-877-1267**.

Insurance Coverage: Although Northfield Hospital and its outpatient clinics have contracts with many different insurance companies, it is not possible to know the details associated with your particular policy. For this reason, it is necessary for you to be responsible for seeing that you meet the requirements of your individual policy to be covered. In order to do this, you may contact the number on the back of your insurance card.

Billing Procedure: Following the study, you will be billed from Northfield Hospital. The physician who reads and interprets your test will bill you separately for his/her services.

The Sleep Study: Generally, the study itself is a very relaxed, easy test. Every effort will be made to assure that you are comfortable and at ease with your surroundings. The study is typically divided into 4 parts:

- **Preparation:** The technician will attach many sensors to your head, chest, arms and legs. This takes about an hour. You will be able to move freely about the room and in bed.
- **Lights out:** Since we only have about 8 hours to conduct the study, you should try to settle into sleep as quickly as possible. You may watch TV (for a short period of time) or read to help you relax, but using your computer or cell phone is discouraged.
- **Diagnostic phase:** The technician will monitor your breathing patterns while you sleep in order to determine whether breathing disturbances occur as you sleep on your side and also when you sleep on your back. If you don't normally sleep in one of these positions, the technician may wake you after approximately two hours and ask you to change position so that a thorough study can be completed.
- **CPAP trial phase:** If the technician has observed and documented enough apneic events to diagnose obstructive sleep apnea, he/she will wake you to fit you with a CPAP mask and allow you to fall back to sleep while he/ she adjusts the CPAP settings to prevent the apneic periods.
- **Please be aware that a glue-like substance will be used on your scalp to adhere the electrodes but is easily removed during normal washing.**

Note to Family Members: Unfortunately, family members are not allowed to stay with you during testing. The hook-up portion of the testing takes an hour and they are permitted to be with you during this time only. If you have special needs and would need assistance, please let us know so arrangements can be made. No pets are allowed.

When you arrive at Northfield Hospital (2000 North Ave, Northfield, MN): Please park on the north side of the hospital. Enter the hospital through the emergency entrance. Give your name to the registration clerk on the right and let them know you are here for a **sleep study in the Respiratory Care Sleep Center**. You will need to register at this time. **Bring your insurance cards with you.**

Do not stop taking any medications, unless specifically requested by your physician. **Please be sure to bring all medications that you need with you and keep them in their original labeled container.** You will need to notify the technician that you have the medication and when you will be self-administer it. If your physician has ordered a nasal spray, use it before you come or bring it with you.

Please take all dietary supplements at home. Dietary supplements are: vitamins, minerals, herbs, or other botanicals, amino acids, metabolite, extract or combination thereof that does not represent a conventional food. Dietary supplements are not to be self administered in the sleep center. Please note that Northfield Hospital is a **completely non-smoking campus**. Smoking is not allowed anywhere, including the parking lot.

PDS *is a leading provider of sleep diagnostic services and partners with your hospital, and over 40 more in the region, to provide exceptional sleep testing services.*

NORTHFIELD

INSTRUCTIONS FOR THE DAY OF YOUR TEST

Northfield Hospital + Clinics

BEFORE your appointment

- ☐ Wash your hair prior to the study, either the night before or the day of your appointment.
- ☐ Avoid using hair products the day of your study, hair should be loose. Please no weaves or braids.
- ☐ Acrylic nails and/or nail polish should be removed prior to your study.
- ☐ Complete the MEDICAL HISTORY and SLEEP SURVEY included with this packet. Please bring this completed packet with you on the night of your study.
- ☐ Eat dinner prior to your appointment.
- ☐ Take your usual medications unless otherwise instructed by your physician. If taking a sleep aid, the technologist will advise when to take it.
- ☐ Prior to your sleep study, please review information on sleep disorders at medbridgehealthcare.com

PLEASE don't forget to

- ☐ Bring your insurance card and ID.
- ☐ Bring comfortable sleeping attire- wear loose fitting **two piece pajama sets** or shorts and a loose fitting t-shirt. Please also bring a robe and slippers.

PLEASE do not

- Take naps the day of your study.
- Consume caffeine after 10:00 AM- (This Includes soda, tea, chocolate and coffee)
- Consume alcohol before the study.
- Please do not arrive before your scheduled appointment time.
- Please do not wear silk pajamas, one piece gowns or sleeping attire that is tight around the ankles.

The sleep lab environment is safe and conducive to sleep. It is dark, quiet and pleasing with a controlled, comfortable temperature.

Going Home

An overnight sleep study usually ends around 5:00AM to 6:00 AM the following morning. If you have someone picking you up please make sure they arrive between 5:30 AM and 6:00 AM. If a "nap study" or Multiple Sleep Latency Test is requested, it follows the overnight study and ends around 4:30 PM.

For Important Questions

Call our office from 8:30 AM until 5:00 PM Monday through Friday. After hours or on the night of your study you may call the nighttime number.

Please be advised that the technician performing your study may be male. If there is an issue with this, please call the scheduling office during normal business hours to make other arrangements.

If You Need to Reschedule

WE UNDERSTAND THAT UNFORESEEN CIRCUMSTANCES MAY ARISE; HOWEVER, DUE TO THE UNIQUE SCHEDULING DIFFICULTY INVOLVED IN AN OVERNIGHT SLEEP STUDY WE REQUIRE A 48-HOUR NOTICE OF CANCELLATION IN ORDER TO AVOID A POTENTIAL $250.00 CANCELLATION CHARGE.

SLEEP QUESTIONNAIRE

Review of Sleep Health

How likely are you to doze off or fall asleep in the situations described in the box below, 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= NEVER doze 1=SLIGHT chance of dozing 2=MODERATE chance of dozing, 3=HIGH chance of dozing

SITUATION	SCORE			
Sitting and Reading	□ 0	□ 1	□ 2	□ 3
Watching TV	□ 0	□ 1	□ 2	□ 3
Sitting inactive in a public place (e.g. theater or 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 circumstances permit	□ 0	□ 1	□ 2	□ 3
Sitting and talking to someone	□ 0	□ 1	□ 2	□ 3
Sitting quietly after a lunch without alcohol	□ 0	□ 1	□ 2	□ 3
In a car, while stopped for a few minutes	□ 0	□ 1	□ 2	□ 3
TOTAL				

Main Sleep Complaint

☐Snoring
☐Pauses in breathing during sleep
☐Daytime fatigue
☐Trouble falling/staying asleep
Other: _____

How long has this been a problem? ☐ 1-2 years ☐ 2-5 years ☐ 6-10 years ☐ 11-20 ☐ >20 Years

Have you been in a car accident due to falling asleep at the wheel? ☐YES ☐ NO
Have you ever had a near miss accident or event due to falling asleep at the wheel? ☐YES ☐ NO
Have you had any other types of accidents due to sleepiness? ☐YES ☐ NO

Sleep Schedule

What time do you go to bed? _____ ☐ AM ☐ PM
What time do you wake up? _____ ☐ AM ☐ PM
Does your routine change on weekends? ☐ YES ☐ NO
How long does it take for you to fall asleep? _____ minutes
How many times do you wake up in the night? _____
How long does it take you to fall back asleep? _____ minutes

In the morning upon awakening, do you feel? ☐ Completely Rested ☐ Partially Rested ☐Not Rested at All

Do you take naps during the day? ☐YES ☐ NO If so how often?

Are they refreshing? ☐YES ☐ NO

Sleep History

Have you ever had a sleep study? ☐YES ☐ NO

Have you ever had a home screening sleep study? ☐YES ☐ NO

If so, please fill out as much information as possible

Date of previous study _____/_____/_____ Location: _____

Date of PAP study _____/_____/_____ Location: _____

Have you ever been on CPAP/BiPAP? ☐YES ☐ NO

Do you still use it? ☐YES ☐ NO

What is your pressure setting? _____ Cm/H20

Are you currently using Oxygen? ☐YES ☐ NO

If so, how many liters per minute? _____ lpm

Sleep Diary

Please complete this two-week diary the days preceding scheduled sleep study. If you receive this less than two weeks before your study date, please complete it from memory the best that you can.

WEEK 1

DAY/DATE	SUN	MON	TUES	WED	THURS	FRI	SAT
Time you woke up							
Time you got out of bed							
Did you wake up refreshed or tired? (circle)	R or T	R or T	R or T	R or T	R or T	R or T	R or T
Note the number of naps taken throughout the day							
Time you went to bed							
Approximate time you fell asleep							
Number of times you awakened during the night							
Note any information affecting sleep for the day							
Note duration of the longest nap (minutes)							

WEEK 2

DAY/DATE	SUN	MON	TUES	WED	THURS	FRI	SAT
Time you woke up							
Time you got out of bed							
Did you wake up refreshed or tired? (circle)	R or T	R or T	R or T	R or T	R or T	R or T	R or T
Note the number of naps taken throughout the day							
Time you went to bed							
Approximate time you fell asleep							
Number of times you awakened during the night							
Note any information affecting sleep for the day							
Note duration of the longest nap (minutes)							

MEDICAL HISTORY

Previous Medical History

EAR, NOSE, THROAT
- □ Sinusitis
- □ Nasal Polyps
- □ Deviated Septum

HEART
- □ Hypertension
- □ Coronary Artery Disease
- □ Heart Attack
- □ Congestive Heart Failure
- □ Arrhythmias
- □ Blood Clots
- □ Pacemaker

LUNG
- □ Asthma
- □ Chronic Bronchitis
- □ COPD
- □ Emphysema
- □ Pulmonary Fibrosis
- □ Pulmonary Hypertension
- □ Recurrent Pneumonia

ENDOCRINE
- □ Thyroid Disease
- □ Diabetes
- □ Menopause (female)
- □ Low testosterone (male)

GI
- □ Reflux disease
- □ Esophagitis
- □ Hiatal Hernia

NEUROLOGICAL
- □ Stroke
- □ Head Injury
- □ Seizures
- □ Anxiety
- □ Neuropathy

MISC
- □ Chronic pain
- □ Degenerative joint disease
- □ Depression
- □ Fibromyalgia
- □ Chronic Fatigue
- □ Migraines
- □ Muscle weakness
- □ Arthritis
- □ Anemia

Medication Listing

Please list all current medications. Include oral contraceptives and vitamins or supplements

Family Medical History

CONDITION	Mother	Father	Siblings
Heart Disease			
Stroke			
High Blood Pressure			
Diabetes			
Cancer			
Sleep Apnea			
Thyroid Disease			
Narcolepsy			
Insomnia			

Review of Symptoms

EAR, NOSE, THROAT
- □ Frequent sinus infection
- □ Frequent ear infection
- □ Post-nasal Drip
- □ Wake with dry mouth

HEART
- □ Palpitations
- □ Chest pain

LUNG
- □ Shortness of breath
- □ Frequent coughing/wheezing
- □ Waking up gasping

GI
- □ Difficulty swallowing
- □ Frequent nausea
- □ Vomiting
- □ Blood in stool
- □ Waking with sour stomach /acid reflux

ENDOCRINE
- □ Increased thirst
- □ Frequent urination
- □ Weight gain
- □ Loss of sex drive

NEUROLOGICAL
- □ Memory Loss
- □ Difficulty concentrating
- □ Irritability
- □ Depression
- □ Visual Loss
- □ Dizziness

MISC
- □ Night sweats
- □ Morning headaches
- □ Night leg cramps/pain
- □ Crawling sensation in legs at night
- □ Leg jerks/kicks during sleep
- □ Vivid dreams
- □ Sleep attacks
- □ Wake feeling paralyzed
- □ Racing thoughts/worry at bedtime

Surgical History

NASAL surgeries ☐YES ☐ NO Explain: _____

THROAT surgeries ☐YES ☐ NO Explain: _____

Other Surgeries ☐YES ☐ NO Explain: _____

Social History

If employed, what are your working hours? Start: _____ ☐ AM ☐ PM Stop: _____ ☐ AM ☐ PM

How long have you been on this work schedule? _____

Are you currently pregnant? ☐YES ☐ NO

Do you Smoke? ☐YES ☐ NO For how long? _____ Amount per day? _____

Do you drink Alcohol? ☐YES ☐ NO Average number you have per day: _____

Do you consume Caffeine? ☐YES ☐ NO Average number you have per day: _____

Physician Listing

Primary Care Physician or practice
List other Physicians or health care practitioners you are currently seeing for treatment:

PATIENT'S RIGHTS AND RESPONSIBILITY

We understand that you are an individual with unique need and perspectives. The following reflects your rights and responsibilities as we work with you to provide care.

You have a right to:

- Be informed, orally and in writing (in advance of your care being provided) of the fees for all services, what payment is expected from third parties, and any charges for which you will be responsible.
- Be informed about the scope of services that we will provide and specific limitations on those services
- Ask questions and receive an understandable explanation of your diagnosis or treatment
- Participate and make informed decisions regarding your care
- Refuse any care or treatment after the consequences of refusing any care or treatment have been fully given to you
- Receive appropriate care without discrimination, in accordance with your physician orders
- Have both your property and you be treated with respect, consideration, and recognition of your dignity and individuality
- Identify personnel members through their proper identification
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source and misappropriation of your property
- Voice grievances and complaints regarding your treatment or care, or lack of respect of your property, without restraint, interference, coercion, discrimination, or reprisal
- Recommend changes in policy, personnel, or care or service without restraint, interference, coercion, discrimination, or reprisal
- Request assistance for concerns, or filing a formal grievance
- Have an investigation of your grievances and complaints regarding your treatment or care that is (or fails to be) furnished, or lack of respect of property
- Confidentiality and privacy of all information contained in your patient record, including Protected Health Information
- Be advised on our policies and procedures regarding the disclosure of medical records.
- Read and copy your own medical record
- Choose or change your medical provider at any time.
- Be informed of any financial benefits when you are referred to a sleep lab center
- Receive treatment without discrimination as to age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression, as well as source of payment for care
- Be respected for your cultural and spiritual beliefs
- Seek assistance (interpreter, wheelchair, etc.) during your visit. (Please make any special arrangements when scheduling your sleep study).
- Have a family member or representative of your choosing present during your care (unless their presence interferes with other's rights, safety, or is medically contraindicated)
- Receive a detailed explanation of any medical bill

You have a responsibility to:

- Keep your appointments, be on time, and when unable to do so, provide 48-hour notice to reschedule or cancel.
- Provide accurate information on your medical history questionnaire
- Communicate any changes in your health or condition
- Be considerate of other patients and staff, including their property
- Ask questions if you do not understand what is being told to you.
- Report any changes in your address, telephone number or financial status.
- Obtain previous medical records when requested.
- Do what you and your healthcare provider have agreed upon with regards to your care and treatment.
- Accept responsibility for refusing treatment or not following your treatment plan.
- Meet your financial obligations associated with the care you received.