SLEEP CENTER OF BUCKS COUNTY, INC. **rev. 3/23/17**

11 Friends Lane, Suite 104
Newtown, PA 18940
(215) 579-2197 Fax: (215) 579-2199

Sleep Study Patient Instructions

Dear Mr/Mrs/Ms _____,

You are scheduled for an overnight sleep study (Polysomnography) on-_____at _____pm. In the event that you need a second night in the Sleep Center to initiate treatment (CPAP) we have scheduled you on _____ at _____p.m. **If for any reason you cannot keep your appointment please call the Sleep Center (215) 579-2197 as soon as possible. At least 48 hours advanced notice is greatly appreciated. Please note that a fee of $150 may be charged for same day cancellations or "no shows".** We strive to make you feel as comfortable and "at home" as possible despite the technical requirements of sleep testing. If you have any additional questions or concerns, feel free to call the Sleep Center.

INSTRUCTIONS:

1. You must bring your prescription with you from your physician for the sleep study. We cannot run the test without the prescription. Bring a photo ID and medical insurance card(s).
2. We have no ability to store refrigerated medications nor can we be responsible for these medications while you are in the center.
3. Patients requiring the services of a caregiver during the night will be required to bring someone with them who can stay throughout the procedures to provide the needed help.
4. If you have been given a sleep diary and packet of questionnaires please complete them and bring it with you on the night of your study. Your Sleep Center physician will review this information at the same time as the sleep study, in order to make a more complete assessment of your sleep problem.
5. Appropriate sleep attire is required: pajamas, nightshirts or sweatpants with a t-shirt, etc. We typically have 3-4 patients per evening at the center and our technicians are both male and female and would appreciate your being appropriately clothed during your study.
6. Your technician will request to weigh and measure you. Please do not be offended. Your weight and height helps us to accurately calculate your BMI, which is very important to our physicians when interpreting your sleep study data.
7. Maintain a regular sleep-wake schedule for the two weeks prior to the sleep study. Get the same amount of sleep on the night before testing as you ordinarily do, and try not to nap on the day of the test.
8. Limit caffeine after lunchtime on the day of your sleep study.
9. Please do not use any hairsprays, hair gels or mousse on the day of the sleep study. If you wear a wig, please remove it before you come for your study. You may be asked to remove braids as well depending on their location. The electrodes, which are affixed to your scalp to monitor sleep activity, will disrupt your "hair-do". These electrodes will be "glued" onto

your scalp with a water soluble paste-like substance that you will have to shampoo out of your hair after your study.

10. Do not wear moisturizer, creams or oils on your skin the day of the study.
11. Women: please come without make-up or be prepared to wash it off when you arrive. If you wear nail polish or fake nails, please remove it/them from at least 3 fingers before coming for your sleep study.
12. Men: If you do not wear a beard, please shave before coming to the Sleep Center. If you do wear a beard, please make sure there is no stubble in areas around your beard.
13. Please have dinner before you arrive in the sleep center. If you typically enjoy a snack before bedtime, bring it with you.
14. Please bring your own pajamas, as well as any other items (special pillow, bathrobe, toothbrush, hairbrush, etc.) that will make you feel more comfortable. Private bathrooms and showers are available in each room in the Sleep Center. Soap, shampoo, conditioner, and towels are provided for your use.
15. **Please arrive after 8pm on the evening of your study because the technologists do not arrive until that time**. The front door will be locked, please ring the doorbell for the technologist to let you in. Please bring your driver's license or other identification along with your insurance cards. If your insurance requires a referral, you must bring it with you if it has not already been provided to the sleep center.
16. Technical set up for the testing will take one to two hours, so please be on time in order not to feel rushed before lights out. We routinely plan for lights out at 11:00 p.m.
17. Each room has a TV and DVD player. You may bring a movie or something to read.
18. The center has many educational tools available to you regarding your sleep study. Please ask your technologist to view an educational DVD or for brochures about sleep studies/CPAP studies. Your technologist will also be available to educate you on the various steps involved with your study.
19. It is preferable to turn the lights out and the TV off at bedtime, but adjustments to this policy can be made as necessary for your comfort.
20. We will allow you to sleep until you awaken on your own or 6:00 a.m., whichever is earlier. We prefer not to awaken you early for work, as it is important to obtain as much sleep data as possible on the study night. If you must awaken earlier than 6 a.m. please let the technologist know prior to lights out.
21. You will be discharged from the center no later than 7:30am. Please arrange to leave the center no later than 7:30am; our technicians are not permitted to stay with you after that time.
22. Breakfast is available to you in the morning featuring, Muffins and snack bars. Coffee, Tea, Orange Juice and Water Bottles are also available. Please request these from your Technician.
23. Follow-up with your doctor is generally scheduled within one month after the sleep testing.
24. We hope that you enjoy your stay. Please complete the survey at the end of your study and give us any feedback so that we may improve our service to our future patients!

Sleep Management Program
For Patients on Nasal CPAP and BiPAP Therapy

Walk-in Clinic NOW Open!!
Alternate Mondays (Please check before coming)
9:00 am-12:00pm
Tuesdays 9:00 am- 4:00pm

Our Sleep Management Program team members work with each patient from the time you start therapy. We have found that every patient adjusts to PAP (Positive Airway Pressure) therapy differently. We look at the individual needs of each patient.

Who would benefit from this program?

- If you are just starting PAP therapy
- If your mask is leaking
- If you are unable to use your PAP device
- If you are unable to sleep > 5 hours a night with your PAP device

Some of the highlights of our program are:

- Mask fitting
- Equipment training
- Downloading of the smart card
- Desensitization for patients having trouble adjusting to therapy
- Patient follow up program

For more information call: (215) 579-2197 or email us at
info@sleepcenterbuckscounty.com

Sleep Center of Bucks County
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Phone (215) 579-2197 Fax (215) 579-2199
Visit us on the web at www.sleepcenterbuckscounty.com

rev 3/23/17

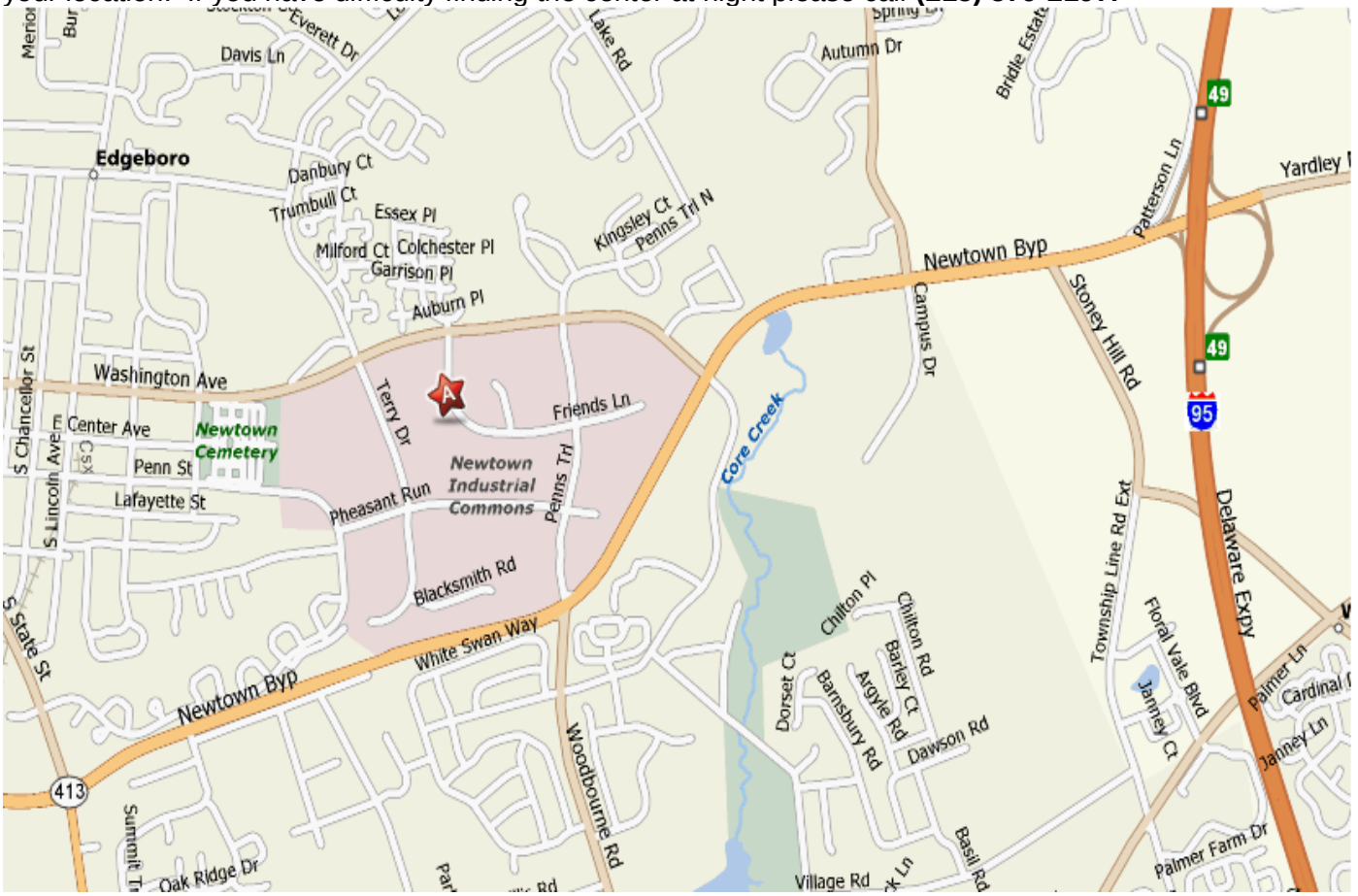
Driving Directions to the Sleep Center of Bucks County

From Philadelphia and South: Take 95 North to Exit 49, Newtown Bypass/PA-332. Make a left on to Newtown Bypass/PA-332 West towards Newtown. Make a right on to Newtown-Yardley Road. Turn left on to Friends Lane. Look for a red brick building with tan and green accents on your right with the number "11" on the front of the building. It is the third building on the right once turning on to Friends Lane. Our center is located in the back of the building in Suite 104. Please park in the lot behind the building.

From New Jersey and East: Take 95 South in New Jersey to 95 South in Pennsylvania. Exit at Newtown Bypass/PA-332, Exit 49 towards Newtown. Follow Newtown Bypass/PA-332 West and make a right on to Newtown-Yardley Road. Turn left on to Friends Lane. Look for a red brick building with tan and green accents on your right with the number "11" on the front of the building. It is the third building on the right once turning on to Friends Lane. Our center is located in the back of the building in Suite 104. Please park in the lot behind the building.

From the West (Richboro, Holland, Northampton): Follow Buck Road/PA-532 North towards Newtown. Make a right on to the Newtown Bypass (Rt. 413/ Rt.332). Make a left on to Penns Trail. Make a left on to Friends Lane. Look for a red brick building with tan and green accents on your left with the number "11" on the front of the building. If you come to Newtown-Yardley Road you have gone too far. Our center is located in the back of the building in Suite 104. Please park in the lot behind the building.

You can visit our website at www.sleepcenterbuckscounty.com for additional driving directions from your location. If you have difficulty finding the center at night please call **(215) 579-2197.**



SLEEP CENTER OF BUCKS COUNTY

SLEEP QUESTIONNAIRE

Patient Name: _____Sex:_____ Age:____ Date: _____Phone #:_____

Occupation: _____ Usual Work Hours/Days: _____

Referring Physician: _____ Family Physician (PCP): _____

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

My Main Sleep Complaint(s) Is:

❑ Trouble sleeping at night For how many months/years? _____

❑ Being sleepy all day For how many months/years? _____

❑ Snoring For how many months/years? _____

❑ Unwanted behaviors during sleep, explain _____

❑ Other, explain _____

Sleep Pattern

	Work Days (Weekday)	Off Days (Weekends)
Typical bedtime:	_____ a.m./p.m.	_____ a.m./p.m.
Typical amount of time it takes to fall asleep:	_____	_____
Typical number of awakenings per night:	_____	_____
List any activities that you normally do during nighttime awakening(s), i.e., restroom, eat, watch TV:	_____	_____
Typical amount of time to fall back asleep after an awakening:	_____	_____
Typical wake up time:	_____ a.m./p.m.	_____ a.m./p.m.
Desired wake up time:	_____ a.m./p.m.	_____ a.m./p.m.

Patient Name:_____

	Work Days (Weekday)	Off Days (Weekends)
How do you usually awaken, i.e., alarm clock?:	_____	_____
Typical time you get out of bed:	_____ a.m./p.m.	_____ a.m./p.m.
Total amount of sleep per night:	_____	_____
Number of naps per day:	_____	_____

Please check all of the following statements that are true about your sleep:

Sleep Habits

- ❑ I usually watch TV or read in bed prior to sleep
- ❑ I often travel across 2 or more time zones
- ❑ I drink alcohol prior to bedtime
- ❑ I smoke prior to bedtime or when I awaken during the night
- ❑ I eat a snack at bedtime
- ❑ I eat if I wake up during the night
- ❑ I typically wake up from sleep to go to the bathroom
- ❑ I have trouble falling asleep
- ❑ I often wake up during the night
- ❑ I am unable to return to sleep easily if I wake up during the night
- ❑ I have thoughts that start racing through my mind when I try to fall asleep
- ❑ I wake up early in the morning, and I am still tired but unable to return to sleep
- ❑ I have nightmares as an adult
- ❑ I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep
- ❑ I sweat a great deal during sleep
- ❑ I cannot sleep on my back

Breathing

- ❑ I have been told that I stop breathing while I sleep
- ❑ I wake up at night choking, smothering or gasping for air
- ❑ I have been told that I snore
- ❑ I have been told that I snore only when sleeping on my back
- ❑ I have been awakened by my own snoring

Restlessness

- ❑ I have uncomfortable feelings in my legs and/or arms when I lie down at night
- ❑ I have to move my legs or walk to relieve the uncomfortable feelings in my legs
- ❑ I am a restless sleeper
- ❑ I have been told that I kick or jerk my legs and/or arms during sleep
- ❑ I have a hard time falling asleep because of my leg movements
- ❑ I have talked in my sleep as an adult
- ❑ I have walked in my sleep as an adult
- ❑ I grind my teeth in my sleep

Patient Name:_____

Daytime Sleepiness

- ❑ I take daytime naps
- ❑ I have a tendency to fall asleep during the day
- ❑ I have had "blackouts" or periods when I am unable to remember what just happened
- ❑ I have fallen asleep while driving
- ❑ I have had auto accidents as a result of falling asleep while driving
- ❑ I fall asleep while watching TV
- ❑ I fall asleep during conversations
- ❑ I fall asleep in sedentary situations
- ❑ I performed poorly in school because of sleepiness
- ❑ I have had injuries as the result of sleepiness
- ❑ I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- ❑ I have had an inability to move while falling asleep or when waking up
- ❑ I have had hallucinations or dreamlike images or sounds when falling asleep or waking up
- ❑ I drink caffeinated beverages during the day: _____cups/bottles/cans per day

Habits

Do you smoke? ❑ Yes ❑ No

If Yes:	What?	Amount per Day	For How Many Years
	❑Cigarettes	_____ pack(s)	_____ years
	❑Cigars	_____ cigars	_____ years
	❑Tobacco	_____ pipes	_____ years

Do you drink alcohol? ❑ Yes ❑ No

If Yes:	What?	Frequency			Amount per Week
	❑Beer	❑Daily	❑Weekends	❑Rare	_____ cans/week
	❑Wine	❑Daily	❑Weekends	❑Rare	_____ glasses/week
	❑Liquor	❑Daily	❑Weekends	❑Rare	_____ shots/week

Social History

- ❑ Sleep alone
- ❑ Share a bed with someone
- ❑ Share a bedroom, but have separate beds
- ❑ Share a dwelling, but have separate bedrooms

Employment Status: ❑Employed ❑Unemployed ❑Retired

- ❑ My job requires driving a vehicle
- ❑ I work with dangerous equipment or substances
- ❑ I am a shift worker on rotating shifts
- ❑ I am a permanent or long-term, third-shift worker
- ❑ I am currently a student

Medical History Patient Name: _____

Vital Statistics

What is your: Height? ____ feet _____inches Weight? _____ pounds Neck Size: _____

What was your weight one year ago? _____ pounds Five years ago? _____ pounds

Current Medications

Medication	Dose	# Times per Day	Medication	Dose	# Times Per Day

Allergies: _____

Past Sleep Evaluation and Treatment

- ❑ I have had a previous sleep disorder evaluation
- ❑ I have had a previous overnight sleep study
- ❑ I have had a daytime nap study
- ❑ I have been prescribed a CPAP or bilevel PAP machine for home use
- ❑ I have had surgical treatment for a sleep disorder
- ❑ I have previously been prescribed medication for a sleep disorder
- ❑ I have previously been treated for a sleep disorder

Past Medical History

- ❑ Hypertension (high blood pressure)
- ❑ Heart Disease
- ❑ Diabetes
- ❑ Stomach or colon problems
- ❑ Lung problems/COPD/asthma
- ❑ Reflux
- ❑ Fibromyalgia
- ❑ Stroke
- ❑ TIA "Light Stroke"
- ❑ Blackouts
- ❑ Seizures
- ❑ Back or joint problems (arthritis)
- ❑ Cancer
- ❑ Thyroid problems
- ❑ Hepatitis/jaundice
- ❑ Hearing impairment
- ❑ Depression or severe anxiety
- ❑ Alcoholism
- ❑ Chemical dependency or abuse

Female

- ❑ Premenstrual syndrome
- ❑ Menopause

Male

- ❑ Prostate problems
- ❑ Erectile dysfunction/impotence

Patient name: _____

List other past medical problems and dates:

_____ _____

_____ _____

_____ _____

_____ _____

List Surgeries and the year

_____ _____

_____ _____

_____ _____

_____ _____

Check any of the following symptoms you have had in the past 12 months:

Yes	No		Yes	No	
❑	❑	Frequent headaches	❑	❑	Frequent heartburn / indigestion
❑	❑	Fainting or passing out	❑	❑	Abdominal pain
❑	❑	Sudden loss of vision or strength	❑	❑	Frequent constipation
❑	❑	Inability to speak	❑	❑	Frequent diarrhea
❑	❑	Hearing loss or ringing in ear(s)	❑	❑	Rectal bleeding / black stools
❑	❑	Hoarseness for more than 2-4 weeks	❑	❑	Difficulty urinating / incontinence
❑	❑	Nosebleeds	❑	❑	Blood in urine
❑	❑	Cough for more than 2-4 weeks	❑	❑	Urinating more than 2 times per night
❑	❑	Coughing up blood	❑	❑	Pain in joints or bones
❑	❑	Shortness of breath or wheezing	❑	❑	Unusual bruising or bleeding
❑	❑	Swelling in feet or ankles	❑	❑	Epilepsy / seizures
❑	❑	Chest pain, tightness or pressure	❑	❑	Change in wart, mole or skin growth
❑	❑	Irregular or sudden, fast heartbeat	❑	❑	Weight loss of more than 5-10 lbs.
❑	❑	Difficulty swallowing or food "sticking"			

Family History

Has an immediate blood relative had any of the following?

Yes	No		Relation	Yes	No		Relation
❑	❑	Cancer	_____	❑	❑	Stroke	_____
❑	❑	Diabetes	_____	❑	❑	Anxiety/Depression	_____
❑	❑	Hypertension	_____	❑	❑	Sleep Apnea	_____
❑	❑	Heart disease	_____	❑	❑	Narcolepsy	_____
❑	❑	Thyroid disease	_____	❑	❑	Other: _____	_____

Patient name: _____

Using the Answer Key below, please circle the number that best applies to your life over the past 6 months.

Answer Key	**1** – Never (Strongly disagree)	**2**- Rarely (Disagree)	**3** – Sometimes (Not sure)	**4** – Usually (Agree)	**5** – Always (Agree strongly)

I have trouble falling asleep	1	2	3	4	5
I wake up often during the night	1	2	3	4	5
At bedtime, thoughts race through my mind	1	2	3	4	5
At bedtime, I feel sad and depressed	1	2	3	4	5
When falling asleep, I feel paralyzed (unable to move)	1	2	3	4	5
When falling asleep, I have restless legs (creepy-crawly feelings, aching, or inability to keep legs still)	1	2	3	4	5
If I wake up during the night, I have trouble getting back to sleep because of restless legs or leg movements	1	2	3	4	5
I wake up suddenly gasping for breath, unable to breathe	1	2	3	4	5
At night my heart pounds, beats rapidly, or beats irregularly	1	2	3	4	5
I sweat a great deal at night	1	2	3	4	5
My sleep is disturbed by sadness or depression	1	2	3	4	5
I have a lot of nightmares (frightening dreams)	1	2	3	4	5
I feel unable to move (paralyzed) after a nap	1	2	3	4	5
I have dream-like images (hallucinations) as I wake up in the morning, even though I know I am not asleep	1	2	3	4	5
I have slept for several days at a time, or at least I have been overwhelmingly sleepy for that long	1	2	3	4	5
I have been unable to sleep at all for several days	1	2	3	4	5
I feel that I have insomnia	1	2	3	4	5
I am very sleepy during the day and I struggle to stay awake	1	2	3	4	5
I got bad grades in school because I was too sleepy	1	2	3	4	5

Patient name: _____

Answer Key **1** – Never (Strongly disagree) **2**- Rarely (Disagree) **3** – Sometimes (Not sure) **4** – Usually (Agree) **5** – Always (Agree strongly)

In the past 6 months I have fallen asleep while eating, talking to someone, riding in a bus or car, reading a book, watching TV or a movie, or listening to a lecture	1	2	3	4	5
I now have trouble doing my job because of sleepiness or fatigue	1	2	3	4	5
I often have to let someone else drive the car because I am too sleepy to drive	1	2	3	4	5
I see dream-like images (hallucinations) either just before or just after a daytime nap, yet I am sure I am awake when they happen	1	2	3	4	5
I often am unable to move (paralyzed) when I am waking up in the morning	1	2	3	4	5
Sometimes I realize I have driven my car to the wrong place, and I can't remember how I did it	1	2	3	4	5
I get "weak knees" when I laugh	1	2	3	4	5
I get sudden muscular weakness (or even a brief period of paralysis, being unable to move) when laughing, angry, or in situations of strong emotion	1	2	3	4	5
I have high blood pressure (or once had it)	1	2	3	4	5
My desire or interest in sex is less than what it used to be	1	2	3	4	5
I am unhappy about loving relationships in my life	1	2	3	4	5
I have considered or attempted suicide	1	2	3	4	5
Someone in my family has been hospitalized for a psychiatric illness or "nervous breakdown"	1	2	3	4	5
I smoke tobacco within two hours before bedtime	1	2	3	4	5
I have problems with my nose blocking up when I am trying to sleep (allergies, infections)	1	2	3	4	5
My snoring or my breathing problem is much worse if I sleep on my back	1	2	3	4	5
My snoring or my breathing problem is much worse if I fall asleep right after drinking alcohol	1	2	3	4	5

SLEEP CENTER OF BUCKS COUNTY

BED PARTNER QUESTIONNAIRE

Name of Patient: _____ Date: _____

Check any of the following behaviors that you have observed the patient doing **while asleep**:

- ❑ Loud snoring
- ❑ Light snoring
- ❑ Twitching of legs or feet
- ❑ Pauses in breathing
- ❑ Grinding teeth
- ❑ Sleep talking
- ❑ Sleepwalking
- ❑ Bedwetting
- ❑ Sitting up in bed while still asleep
- ❑ Head rocking or banging
- ❑ Kicking with legs
- ❑ Getting out of bed while still asleep
- ❑ Biting tongue
- ❑ Becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) that you checked above?

_____

_____

_____

_____

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, how many times during the night and whether it occurs every night.

_____

_____

_____

_____

_____

If you have heard loud snoring, describe it in more detail. Include descriptions of any pauses in breathing or occasional loud "snorts" that you may have noticed.

_____

_____

_____

_____

_____

SLEEP CENTER OF BUCKS COUNTY

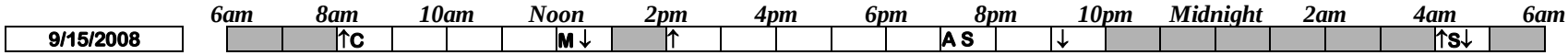
SLEEP LOGS

Name: _____

INSTRUCTIONS: Complete these logs in the morning and the evening. Do not complete them during the night. Write additional comments on the back. Bring these logs with you for your appointment or mail them to your doctor.

1. Leave the boxes BLANK to show when you are awake.
2. SHADE or color the boxes to show when you are asleep.
3. ARROW DOWN -↓- when you lie down to sleep.
4. ARROW UP -↑- when you wake up (include naps).
5. "M" for meals, "S" for snacks, "C" for caffeine, "A" for alcohol.
6. Include notes below each week or on the back.

EXAMPLE:



FIRST WEEK

Date	*6am*	*8am*	*10am*	*Noon*	*2pm*	*4pm*	*6pm*	*8pm*	*10pm*	*Midnight*	*2am*	*4am*	*6am*

SECOND WEEK

Date	*6am*	*8am*	*10am*	*Noon*	*2pm*	*4pm*	*6pm*	*8pm*	*10pm*	*Midnight*	*2am*	*4am*	*6am*

Patient name: _____

SLEEP CENTER OF BUCKS COUNTY

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

Rate each description according to your normal way of life in recent times. Even if you have not been in some of these situations recently, try to determine how sleepy you would have been. Use the following scale to choose the best 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)	_____
Sitting as a passenger in a car, for an hour without a break	_____
Lying down to rest in the afternoon when your schedule permits it	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
Sitting in a car, while stopped for a few minutes in the traffic	_____

Reference: Johns, MW. A new method for measuring daytime sleepiness: the Epworth Sleepiness

For Sleep Center Use Only:

❑ I have reviewed the Sleep History Questionnaire and all information is completed.
❑ There is missing information which the patient cannot complete. Please explain: _____
_____

❑ I have sent the Sleep Diary home with the patient to complete and bring to their next office visit.

Tech Signature:_____
Date: _____