Citrus Pulmonary Consultants and Sleep Disorders Center
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Name: _____ DOB: _____ Date of Service: _____

Dear Sleep Patient,

In order to provide you with the best possible service, please read the patient instructions attached. If you have any questions, please contact our office at (352)795-1999 as soon as possible. Please fill out the enclosed questionnaire and return to the sleep technician on the night of your study. 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.

Due to our extensive waiting list, please contact our office if you are unable to keep your appointment. **We charge a $50.00 fee for any sleep study that is not canceled within 24 hours and for any patient who does not show for their study.** If you need to reach the sleep lab during study hours (8pm-6am), please call (352)795-6076. Please do not leave a message on our answering machine. If you do not receive an answer, please continue to call until the technician answers the phone. An automated phone system will call to confirm your appointment a few days in advance.

Your appointment date is:_____ at 8:30pm.

Please note that this packet is front and back.

Name: _____ DOB: _____ Date of Service: _____

A Comprehensive Sleep Disorder Center

Relief for your sleep disorder can be found at Citrus Pulmonary Consultants and Sleep Disorders Center. This center is one of the most comprehensive facilities in Citrus County, and provides physician evaluations, state-of-the-art diagnostic testing, and treatment for all sleep related disorders. In addition, this center is one of the few in Citrus County to have multiple board-certified sleep disorder physicians, certified through the American Board of Sleep Medicine. Our technician staff is certified by the Board of Registered Polysomnographic Technologists.

There are at least 84 known sleep disorders, including:

- ❑ Breathing problems, such as Sleep Apnea, that is a condition in which you stop or have shallow breathing in your sleep. This condition is typically associated with loud snoring and daytime sleepiness. If left untreated, sleep apnea may cause increased high blood pressure and mortality.

- ❑ Neurological problems, such as narcolepsy, that is a condition in which the patient has sudden, uncontrollable daytime sleepiness, vivid dreaming and "sleep attacks," loss of muscle control, and hallucinations.

- ❑ Insomnia, or the inability to initiate or maintain sleep. Although this can be a result of emotional or situational circumstances, insomnia lasting more than a few weeks may be the result of a more serious problem.

Sleep Testing (Polysomnography)

Polysomnography, also known as a "sleep study," is a test performed on patients who have a suspected sleeping disorder. This procedure is performed as an outpatient procedure and is non-invasive. The procedure is performed by a certified and highly-trained technologist, who will apply a series of electrodes and monitoring devices on the surface of the patient's head and body. The application of monitoring devices causes no discomfort to the patient. Testing is performed in a private bedroom, separate from the technologist monitoring the study located in an adjacent room. The technologist remains in the facility for the entirety of the study, lasting from approximately 8:30pm through 7:00am. Upon completion of the exam, the patient is able to commence normal activities.

Treatment and Follow Up

Full evaluation of the sleep study data takes approximately seven to ten business days, and results are forwarded to the ordering physician. If the patient is following with Citrus Pulmonary Consultants and Sleep Disorders Center, a follow-up appointment will be made within two weeks of the study. If the ordering physician is located outside of the practice, the results will be forwarded to the ordering physician for evaluation and management of the results. Once an accurate diagnosis has been reached, treatment for the sleep disorder can begin.

Tips for a Better Night Sleep

- ❑ Use the bedroom only for sleep
- ❑ Avoid caffeine and alcoholic beverages four to six hours before bedtime
- ❑ Avoid strenuous exercise four to six hours before bed
- ❑ Minimize light, noise, and extreme temperatures in the bedroom
- ❑ Avoid large meals at bedtime; however, a light snack may help promote sound sleep
- ❑ Maintain a regular wake time each day
- ❑ Only go to sleep when drowsy; if unable to sleep after twenty minutes, leave the bedroom and perform an activity until drowsy and attempt sleep again
- ❑ Avoid napping during the day

Name: _____ DOB: _____ Date of Service: _____

Important Reminders for the Day of the Study

- ❑ Eat a normal dinner at your normal time
- ❑ Take your normal medications as prescribed by your physician; however, please refrain from taking any sleeping medication until you have arrived at our facility
- ❑ Please shower and thoroughly clean skin prior to arrival. Please do not apply makeup, creams, gels, oils, or lotions. This allows the monitoring devices to adhere properly to your skin.
- ❑ Please wear a two-piece set to sleep in. This allows the technologist to apply the monitoring devices while also allowing more privacy for the patient.
- ❑ Please bring your completed questionnaire to the technologist when you arrive.
- ❑ Please avoid naps during the day of your test.
- ❑ Please bring any items that will make your stay more comfortable. These items may include snacks, beverages, toiletry items, extra pillows, and extra blankets. You do **not** need to bring oxygen tanks or masks if required by your physician. Oxygen and masks will be provided by the technologist.

You have been diagnosed with possible sleep apnea. This condition may adversely affect your driving. Patients with sleep apnea are often three to four times more likely to have a motor vehicle accident. These accidents may cause serious injury or death to you and others.

If you have had an accident or near accident due to sleepiness or inattention, you should discontinue driving and operating dangerous machinery until your sleep disorder has been diagnosed and treated by your physician and you are no longer sleepy or inattentive while driving. It is your responsibility to refrain from driving if you are sleepy or 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; however, potential consequences of refusing treatment can include, but are not limited to, increased risk of stroke, heart disease, high blood pressure, diabetes, and motor vehicle accidents. Because of this, your physician has advised you to have a sleep study and proper follow-up treatment. Failure to comply is against medical advice, and may result in adverse consequences.

Please sign below that you understand the above statements and the information in this packet.

_____ _____

Patient Signature Date

Name: _____ DOB: _____ Date of Service: _____

Sleep Questionnaire

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Phone Numbers:
Home: _____ Cell: _____ Work: _____

Occupation: _____ Employer: _____

Referring Physician: _____

Reason you have been referred for a sleep study: _____

Do you take any medications? If so, please list all over the counter and prescribed medications. If you take more medication that space provided, please attach a list.

Medication	Dosage	Frequency	Duration

For each of the following beverages listed below, please give the average daily amount of consumption. Please keep in mind that most glasses used in homes are larger than eight (8) ounces.

Caffeinated Coffee	
Decaffeinated Coffee	
Hot or Iced Tea	
Soft Drinks	

On average, how many alcoholic beverages do you consume? Please keep in mind the size of cans and glasses.

Weekday Drinks/Day	Weekend Drinks/Day	What kind?

Do you smoke? ❑ Yes ❑ No For how long? _____ What do you smoke? _____
How much? _____

Do you require separate rooms from your spouse or partner? ❑ Yes ❑ No
Do you sleep alone? ❑ Yes ❑ No Do you have a regular sleep partner? ❑ Yes ❑ No
If yes, please explain: _____

Please list your normal sleep schedule below.

Awake/Asleep Times	Weekdays	Weekends
When do you go to sleep?		
When do you wake up?		

Name: _____ DOB: _____ Date of Service: _____

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? If the question does not apply to you, please indicate how you feel sleepiness would affect you in that situation.

Use the following scale to indicate the most appropriate response for each situation.

0 – You would never doze off.
1 – Slight Chance of dozing off.
2 – Moderate Chance of dozing off.
3 – High chance of dozing off.

While sitting or reading?	
While watching television?	
Sitting inactive in a public place?	
Riding in a car for one hour without a break?	
Lying down to rest in the afternoon?	
Sitting and talking to someone?	
Sitting quietly after lunch (without consuming any alcoholic beverage)?	
Stopped in traffic for a few minutes (as the driver)?	
Total:	

Please include any comments that you feel are important to the technologist or the physician to review.

_____

_____

_____

_____

_____

_____ _____

Patient Name Date

Name: _____ DOB: _____ Date of Service: _____

Please answer the following questions with a yes or no answer and provide an explanation for your response.

Question	Yes/No		Response
Do you have trouble falling asleep at night?		How long does it take on average to fall asleep?	
Do you wake up frequently at night?		How many times per night?	
Do you get up to use the restroom?		How many times per night?	
Have you been told that you snore?		Loudly?	
Do you experience difficulty breathing at night?		How often?	
Do you experience incontinence at night?		How often?	
Do you sleep with pillows at night?		How many?	
Do you awake gasping or choking?		How often?	
Do you awaken with coughing spells?		How often?	
Do you wake up in the morning feeling tired/unrefreshed?		How often?	
Do you wake up in the morning with a headache?		How many times per week?	
Do you wake up in the morning feeling disoriented/foggy?		How many times per week?	
Are you bothered by sleepiness during the day?		How often?	
Do you fall asleep at inappropriate times during the day?		When?	
Have you ever had an accident while driving due to falling asleep?		Multiple times?	
Have you gained weight recently?		How much over what period of time?	
Have you lost weight recently?		How much over what period of time? Intentional?	
Have you noticed yourself becoming increasingly irritated lately?		How often?	
Do you ever find yourself somewhere that you can't remember driving to?		How often?	
Do you experience cramping, jerking movements in your legs?		If so, when?	
When you laugh/get angry, do you feel like you may collapse?		How often?	
Have you suddenly fallen asleep for no reason?		How often?	
Do you experience sudden body weakness?		Are you aware of your surroundings?	
Do you sleepwalk?		How often?	
Do you talk in your sleep?		How often?	
Do you grind your teeth in your sleep?		How often?	
Do you ever wake up screaming?		How often?	
Are you prescribed oxygen at night?		What is your current setting?	
Have you experienced seeing things or hearing things that aren't real?		If so, when?	
Did you fall asleep answering these questions?			

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