



What to Expect for Sleep Study

Date/Time of your sleep study appointment: _____

Location of your sleep study appointment: _____

Steps to a Better Night's Sleep

1. Insurance verified by SLEEPTRENDS staff
2. Evaluation appointment scheduled
3. Evaluation performed by physician at SLEEPTRENDS
4. Sleep study is performed at the SLEEPTRENDS of your choice
5. Sleep study data is read and translated by SLEEPTRENDS physician
6. Diagnosis and treatment will be discussed with you and your primary care physician

Preparation

- Please advise SleepTrends in advance of any special needs you will require.
- Please shower and wash your hair. Hair should be dry and free of conditioners, hair spray, styling gels, etc. Leads must be able to touch scalp for accurate testing.
- Please remove make-up, and do not apply moisturizing lotion to face or legs.
- We will need one fingernail to be free of acrylic or dark polish.
- Please refrain from drinking caffeine and alcohol on the evening of your study.
- Please take any usual medications unless your doctor has specifically advised against doing so.

What to Bring

- Please bring something comfortable to sleep in.
- Please have your identification, insurance card, and completed paperwork.
- If you have a co-pay or deductible, we accept credit, checks, and cash. (If paying by cash, please have an exact amount as change is unavailable.)
- Please feel free to bring your favorite pillow and blanket. (not required)
- Please feel free to bring a book to read prior to testing. (not required)

What to Expect

- Pagers and cell phones must be turned off during testing to avoid interference.
- Overnight guests, other than caregivers or legal guardians, cannot be allowed.
- Please make appropriate arrangements to leave in the morning, usually between 5 and 6 A.M.
- After the study, your results will be available within 3 to 5 days.



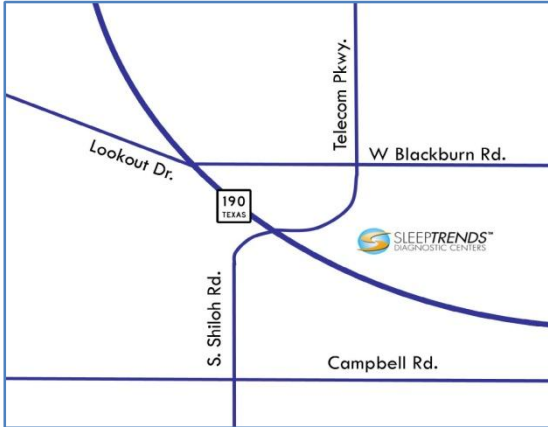
Testing Procedure

- Upon arriving, you will be asked to complete a pre-sleep questionnaire and sign a consent form to perform testing.
- Payment of co-pays, deductibles or co-insurance will be collected. If you are unsure of the amount you will be responsible for, please call 866-511-5678.
- You will be asked to prepare for bed prior to the technician attaching the necessary leads.
- Testing begins by approximately 10:30 P.M.
- The technician will be monitoring the test with video and audio, allowing you to call for assistance to get out of bed in order to use the restroom.
 - Brain waves (electrodes placed on the scalp)
 - Eye movements (electrodes placed by the eyes)
 - Chin muscle tone (electrodes placed on near the chin)
 - Heart rate (electrodes placed on the chest)
 - Leg movements (electrodes placed on the legs)
 - Airflow (sensor placed near the nose and mouth)
 - Breathing effort (two elastic belts placed around chest and abdomen)
 - Oxygen saturation level (small sensor attached to the finger or ear lobe)
 - Audio and digital video recording
- Patients are required to sleep on their back for part of the study in order to get the most accurate data.
- A minimum of 6 hours of testing is required. Requests to end the study earlier will be accommodated when possible.

Post Test Expectations

- There will be a post sleep questionnaire and a satisfaction survey to complete in the morning.
- Residual paste is in the hair and adhesive from the tape will remain when the equipment is disconnected. Shower facilities are available at select locations.
- Towels will be provided, but please remember to bring your own toiletries.
- A breakfast bar will be available to you to start your day off right.

Results will be forwarded to your physicians office within 3 to 5 business days.



7150 N. President G. Bush Freeway, Suite 205

Garland, TX 75044

From **Hwy 75**, go East on President. G Bush Fwy, and exit Shiloh. At Shiloh/Telecom, turn left. SleepTrends will be on the right, located in the Baylor Medical Plaza.

From **SH 78**, go West on President. G Bush Fwy, and exit Shiloh. At Shiloh/Telecom, turn right. SleepTrends will be on the right, located in the Baylor Medical Plaza.

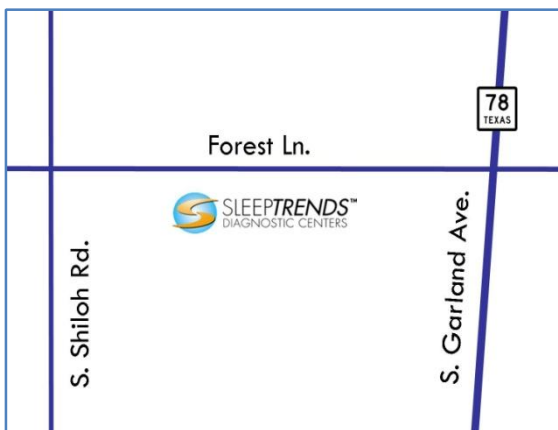


1611 N. Belt Line Road, Suite C

Mesquite, TX 75149

From **I-635**, go East on Hwy 80, and exit at Belt Line Rd. Turn right at Belt Line Rd. After Range Rd, SleepTrends will be on the right.

From **Sunnyvale**, head West on Hwy 80, and exit at Belt Line Rd. Turn left at Belt Line Rd. After Range Rd, SleepTrends will be on the right.



2046 Forest Lane, Suite 110

Garland, TX 75042

From **I-635**, exit at Shiloh Rd., and go North. At Forest Lane, turn right. SleepTrends is on the right.

From SB **SH 78**, at Ave B, turn right. Name changes to Forest Lane. SleepTrends is on the left after W. State St.

From NB **SH 78**, at Ave B, turn left. Name changes to Forest Lane. SleepTrends is on the left after W. State St.

Sleep History Questionnaire

Name: _____ DOB: _____ Date: _____
 Male Female Height: _____ Weight: _____ Neck size: _____ Marital Status: M S D W
 Occupation: _____ Emergency Name / #: _____
 Primary Physician: _____ Referring Physician: _____

Medical History

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bypass Surgery | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Nose Fracture |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Nasal Surgery |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Other: _____ | | Current Medications: | |
| <input type="checkbox"/> Medication allergies: _____ | 1. _____ | | |
| <input type="checkbox"/> Smoking: # of years: _____ Packs per day: _____ | 2. _____ | | |
| Have you quit? <input type="checkbox"/> No <input type="checkbox"/> Yes, on this date: _____ | 3. _____ | | |
| <input type="checkbox"/> Recent change in weight: _____ | 4. _____ | | |

On an average night:

How long does it take you to fall asleep? _____
 How many hours do you spend in bed? _____
 How many hours do you sleep at night? _____
 Number of awakenings: _____
 Length of awakenings: _____
 Do you feel refreshed in the morning? Yes No
 Do you awaken with a headache? Yes No
 What is your usual Bedtime? _____
 What time do you get up in the morning? _____

Do you or have you ever been told that you:

Grit or grind your teeth? Yes No
 Have night sweats? Yes No
 Experience leg cramps or tingling? Yes No
 Repeatedly kick your legs while asleep? Yes No
 Awaken with a sour or bitter taste in your mouth? Yes No
 Hold your breath while you sleep? Yes No
 Awaken choking, gasping, or short of breath? Yes No
 Fall asleep unintentionally? Yes No
 Snore? Since when? _____ Yes No

Do you experience any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Light Snoring | <input type="checkbox"/> Snoring interrupted by silence / gasping |
| <input type="checkbox"/> Moderate Snoring | <input type="checkbox"/> Trouble concentrating |
| <input type="checkbox"/> Loud Snoring | <input type="checkbox"/> Falling asleep at inappropriate times |
| <input type="checkbox"/> Choking | <input type="checkbox"/> Short Temper |
| <input type="checkbox"/> Talking in Sleep | <input type="checkbox"/> Lack of energy |
| <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Loss of Libido |
| <input type="checkbox"/> Restless Sleep | <input type="checkbox"/> Fatigue |

Do You ever:

- Read while in bed.
 Watch TV in bed. (or bed-partner does)
 Share your bed with anyone.
 Take naps. How long? _____
 Are they refreshing? Yes No
 Awake to urinate during the night.
 How often? _____

Are you experiencing excessive daytime sleepiness? Yes No How Long? _____
 Are you experiencing restlessness, a need to move your legs or pace when sitting for long periods of time?
 Yes No During Awakenings? Yes No
 (Men) Do you ever have trouble achieving erections? Yes No How Long? _____
 Do you feel anxious, depressed or irritable? Yes No Please Explain: _____

Please explain your sleep problem in detail:

Signs & Symptoms

Name: _____ Date: _____

- Anxiety / Depression
- Falling Asleep at Inappropriate Times
- Fatigue or Malaise
- High Blood Pressure
- Insomnia of unknown etiology
- Insomnia with Apnea
- Irritability
- Loss of Energy
- Loss of Libido
- Loud or Disruptive Snoring
- Morbid Obesity
- Morning Headaches
- Daytime sleep attacks
- Nocturnal Awakenings / Arousals during sleep
- Obesity
- Periodic Limb Movements during sleep
- Restless Legs just prior to, or while falling asleep
- Shift Work Disorder
- Somnolence or Drowsiness
- Witnessed Breathing Pauses during sleep

Epworth Sleepiness Scale

Name: _____ Date: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? If you have not done these activities recently, think of how they would have affected you.

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

** It is important that you circle a number (0 to 3) on each question.*

<u>Situation</u>	<u>Chance of Dozing</u>
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactively in a public place (e.g., a theater or meeting)	0 1 2 3
As a passenger in a car for about an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking	0 1 2 3
Sitting quietly after lunch (without alcohol)	0 1 2 3
In a car while stopped in traffic	0 1 2 3

TOTAL _____