At your physician’s request, you are scheduled for a sleep study at the Sleep Disorders Center at Indiana University Health West Hospital.

We are located in Indiana University Health West Hospital at 1111 North Ronald Reagan Parkway which is 3.5 miles west of I-465 on 10th Street.

**Come in through the main entrance** of the hospital. The main entrance gets locked each night. If the second set of doors does not automatically open, you will need to press the button (which has an intercom) on the right of the entryway so that security could open these doors for you. **You will need to let them know you are here for a sleep study.** Once they open the door for you, walk towards the information desk and turn left. Get on the elevator just past the gift shop. Go up to the 3rd floor, **Room 305** (Sleep Disorders Center). Our office is on the left as soon as you exit the elevator.

You may receive a phone call from the registration department on the day of your test with check in instructions.

Please arrive for your appointment at your scheduled time. There is no need to arrive early unless you are instructed to do so.

You will spend approximately 8-10 hours in the Sleep Disorders Center and you should be finished between 6:30-7:30am.

**Insurance:**

Some insurance companies require pre-certification. We do attempt pre-certification on your behalf. Please note, pre-certification is not a guarantee of payment. If you have any questions or concerns about the coverage your insurance will pay, we recommend you contact your insurance company directly to provide you with this information. The sleep study is an outpatient test.

**Late Cancellation or No Show Policy:**

If you have any questions or need to reschedule, please call the Sleep Disorders Center at **317.217.3586**. If the phone is answered electronically, please leave a message with your name, telephone number, date of appointment. This is also the number to give family in case of an emergency. **If you are going to be late, please call as soon as possible. If you do not arrive (or call us) within 15 minutes of your scheduled appointment time, we may not be able to perform your test. You may be assessed an equipment and room preparation fee of $200.00 if at least 24 hours notice is not given for a cancellation. You will be responsible for the fee. It will not be billed to your insurance company.**
**On the day of your sleep test, remember to:**

- Go about your normal day, unless someone from the sleep center advises you otherwise. This includes performing all your usual activities and taking all of your usual medications. If you need to take medications before bedtime, bring them with you. Sleeping aids or any other specific medications are NOT dispensed in the sleep center. Please refer to your physician regarding any medication questions.

- Bring all medications, personal items, and a change of clothing for the next day.

- Shower facilities, towels, toiletries and hair dryers are available.

- We do have pillows in the sleeping rooms, but you may bring your pillow from home if you like.

- Avoid taking any naps on the day of your sleep test.

- Avoid any caffeine and/or alcohol after 5:00pm on the day of your sleep test.

- Please have your hair clean and dry the day of your test. Refrain from using conditioners, mousse, oils, gels, or hair spray. Do NOT apply any heavy creams or lotions to your skin. Any use of these items can alter the quality of your test.

- Please have your evening meal before arriving in the sleep center. If you wish to bring a snack, feel free to do so.

- If you have special needs (i.e. hospital bed, bedside commode, oxygen, nebulizer, etc.) and you have not already advised your scheduler, please call 317-217-3586 prior to your appointment. In some cases, it may be necessary for you to bring your equipment from home.

**Items to bring with you:**

- Pajamas or loose fitting clothing that is 2-piece to sleep in. Please no silk or satin pajamas or gowns. Most people wear shorts and a T-shirt.

- All medications, personal items, change of clothing for the next day.

- Sleep/Medical History Forms (if included in this packet), Identification and Insurance Card.

**After the completion of your test:**

Please feel free to ask questions or voice any concerns to the technicians; however, they cannot discuss any test results until the physician has interpreted the study. Results will be forwarded within 7-10 days from your study date. Your attending physician or the sleep physician will contact you regarding your results and treatment options.

*Extensive facilities, technical equipment and trained staff are required to perform your sleep study. These resources are being scheduled and reserved for you. Because of this, it is essential that you come for your sleep study as scheduled or give at least 24 hours notice if you are unable to make your reserved time.*

*Thank you for allowing us to assist in your care.*

revised 1/2011
Finding the Sleep Disorders Center at Indiana University Health West Hospital

Park in the Main Entrance parking lot. Come in the main entrance of the hospital.

****If the second set of doors do not automatically open, you will need to press the button on the right (which has an intercom) so that security could open these doors for you. **You will need to let them know you are here for a sleep study.**

Walk towards the information desk and turn left.

Take the elevator just past the gift shop. Go up to the 3rd floor, **Room 305** (Sleep Disorders Center). Our office is on the left as soon as you exit the elevator.
Questions about Sleep Testing

Why do I need a sleep test?
Your doctor has ordered a sleep test because he suspects a primary dysfunction of the neural mechanism responsible for normal sleep.

What symptoms might lead my doctor to suspect I have a sleep disorder?
You may have excessive daytime sleepiness, fatigue, depression, insomnia, hypertension, morning headaches, poor concentration and memory loss. Perhaps your bed partner has complained of loud snoring/snorting, teeth grinding, active leg/body movements during sleep and many others.

What is a sleep test?
The technician assigned to you will apply various small sensors to your head, chest, legs, finger, nose, mouth, and throat. These specialized devices will record the details of your sleep and tell the doctor about the quality of sleep you are getting. Oxygen level, heart rhythm, breathing pattern and various other things are also monitored while you sleep. This is an outpatient test.

When do I go home? How long does this test take?
If your physician orders night time testing only---you will be released in the morning. If you need awakened by a certain time, let the night technician know. You should be released between 6:30am-7:30am. We try to have lights out (and the TV off) by 11:00pm (or 11:30pm if you’d like to see the news). It will take the technician approximately 45 minutes to apply the recording devices and approximately 10 minutes to calibrate the devices to you. During the calibration you will follow simple verbal commands given by the technician. Insurance requires that we record a minimum of six hours of recorded data, although we normally record seven hours or more.

May I bring someone with me to stay overnight?
We do not have additional rooms or beds in our sleep center for this purpose. There are some hotels near by.

What if I need something or have to go to the restroom in the middle of the night?
Once you are connected to the testing equipment, you can move freely in bed. If you need to leave the bed (go to the restroom), the technician will temporarily disconnect you from the recording machine. A microphone system is present to pick-up your calls and the technician will be there promptly to help you.

Is there anything else I should know?
Yes, if it becomes obvious that you have severe breathing irregularity during sleep, we will awaken you in order to place a mask on you that will be attached to a CPAP machine.

What is CPAP? What does CPAP do?
CPAP stands for Continuous Positive Airway Pressure. It is a small bedside unit that has tubing and a small mask that is placed gently over your nose and delivers air into your airway. It merely assists your body in breathing by keeping the airway open while allowing you to rest so that the breathing irregularity does not keep you from sleeping properly.

How soon can I expect a report on the results of my test?
Upon completion of your test there are approximately 850-1000 pages of data to be evaluated. Once the test has been read, the ordering physician or the sleep physician may call you and give his impression of the test and go over treatment options, if you have previously been in for an office visit. If you have not had an office visit with the sleep physician, he will have one of the medical assistants call to schedule an appointment at which time he will go over the results and treatment options. The physician who ordered your test will also be provided a copy of the test results. This process will take 7-10 business days to complete.

We want your stay in the sleep lab to be beneficial in diagnosing your sleep problems and as pleasant as possible. Please help us attain these goals by telling us of any concerns when they arise.
PATIENT INFORMATION

Name ___________________________________________________________ Date _____________

Address ______________________________________________________________________________________________________

City & State __________________________________________________________________________________________ Zip _________

Home Phone (   ) __________________________ Work Phone (   ) __________________________

Birth Date ___________________________ Age ___________ SS#_____________________________________

Height __________________________  Weight ________________________  Sex   M   F

Marital Status __________________  Spouse’s Name _____________________________________________

Insurance Company ________________________________________________ ID# ______________

Family Physician ____________________________________________ Phone (   ) ______________

Physician Address ____________________________________________________________________________________________

City & State __________________________________________________________________________________________ Zip _________

Referring Physician ____________________________________________ Phone (   ) ______________

Address __________________________________________________________________________________________

City & State __________________________________________________________________________________________ Zip _________

Patient Employer ____________________________________________ Employer Phone (   ) ______________

Employer Address ____________________________________________________________________________________________

City & State __________________________________________________________________________________________ Zip _________

Emergency Contact ____________________________________________ Relationship to Patient ______________

Contact’s Phone (   ) __________________________________________ Other Phone (   ) __________________________

Contact’s Address ____________________________________________________________________________________________

City & State __________________________________________________________________________________________ Zip _________
A) **CHIEF COMPLAINT** - Please describe your sleep/wake problem and how long it has been present.

_______________________________________________________________________________________________

_______________________________________________________________________________________________

B) **TYPICAL SLEEP TIMES:**

<table>
<thead>
<tr>
<th></th>
<th>Weekdays</th>
<th>Weekends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Go to bed:</td>
<td></td>
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<tr>
<td>Get out of bed:</td>
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<tr>
<td>Naps during the day:</td>
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<tr>
<td>Time spent asleep:</td>
<td></td>
<td></td>
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</tbody>
</table>

How many times do you awaken from sleep each night on average? ______________________________

What do you think causes this or what do you notice at that moment? ______________________________

C) **PAST MEDICAL HISTORY** - List any significant health problems in the following areas.

<table>
<thead>
<tr>
<th>Type of Problem</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies to medications</td>
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<tr>
<td>Head or nervous system</td>
<td></td>
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<tr>
<td>or stroke</td>
<td></td>
</tr>
<tr>
<td>Eyes, ears, nose, throat or mouth</td>
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<tr>
<td>Upper airway allergies</td>
<td></td>
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<tr>
<td>Breathing (lungs)</td>
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<tr>
<td>Heart, circulation or blood pressure</td>
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<tr>
<td>Stomach, digestive</td>
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<tr>
<td>Kidney diseases</td>
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<tr>
<td>Anxiety or depression</td>
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<tr>
<td>Other medical problems</td>
<td></td>
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<tr>
<td>(diabetes, thyroid disorder)</td>
<td></td>
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<tr>
<td>Arthritis</td>
<td></td>
</tr>
</tbody>
</table>

D) **PAIN**

Origin ____________________________ Onset ____________________________

Location ____________________________ Quality (i.e. burning, dull ache) ____________________________

Intensity Level: 0 1 2 3 4 5 6 7 8 9 10 Frequency/Duration ____________________________

Aggravating/Relieving Factors ____________________________

Pain Management History ____________________________
List all prescriptions and non-prescription medicines. Use sides of page if necessary.

1. ___________________________ Dose ____________________ times/day ________________
2. ___________________________ Dose ____________________ times/day ________________
3. ___________________________ Dose ____________________ times/day ________________
4. ___________________________ Dose ____________________ times/day ________________
5. ___________________________ Dose ____________________ times/day ________________
6. ___________________________ Dose ____________________ times/day ________________
7. ___________________________ Dose ____________________ times/day ________________

Please list all medicines that you are allergic to: ______________________________________
_____________________________________________________________________________
_____________________________________________________________________________

The following list includes possible complaints or problems associated with sleep at night. Please circle the number for each complaint/problem listed. Use the following scale:

0 = never
1 = rarely (once or twice in your life)
2 = sometimes (once or twice each year)
3 = often (once or twice each month)
4 = very often (once or twice each week)
5 = always (every night)

0  1  2  3  4  5   snoring disturbs others
0  1  2  3  4  5   gasp or wake up from sleep choking
0  1  2  3  4  5   stop breathing for short periods
0  1  2  3  4  5   feel paralyzed when falling asleep or waking up
0  1  2  3  4  5   have near hallucinations or dreamlike images when falling asleep or just waking up
0  1  2  3  4  5   have leg cramps at night
0  1  2  3  4  5   uncomfortable, crawling sensation in legs that is relieved by moving or walking
0  1  2  3  4  5   jerk your arms or legs at night
0  1  2  3  4  5   sleep restlessly
0  1  2  3  4  5   have aches or pains at night Please describe:____________________________________
0  1  2  3  4  5   have problems falling asleep or staying asleep
0  1  2  3  4  5   lie awake feeling depressed, worried, or anxious
0  1  2  3  4  5   grind your teeth at night
0  1  2  3  4  5   frightening dreams or nightmares
0  1  2  3  4  5   walk in sleep
0  1  2  3  4  5   talk in sleep
The following list includes possible daytime complaints and problems associated with sleep. Please circle the number for each complaint/problem listed. Use the following scale:

0 = never
1 = rarely (once or twice in your life)
2 = sometimes (once or twice each year)
3 = often (once or twice each month)
4 = very often (once or twice each week)
5 = always (every night)

0 1 2 3 4 5 feel unrefreshed in the morning after sleep
0 1 2 3 4 5 find it hard to wake up in the morning
0 1 2 3 4 5 wake up with headaches
0 1 2 3 4 5 irritable
0 1 2 3 4 5 unable to concentrate
0 1 2 3 4 5 poor memory during the day
0 1 2 3 4 5 yawn frequently during the daytime
0 1 2 3 4 5 feel drowsy or sleepy during the day
0 1 2 3 4 5 daytime sleepiness interferes with normal activities
0 1 2 3 4 5 daytime fatigue
0 1 2 3 4 5 have hallucinations or dream-like mental images during the day
0 1 2 3 4 5 have attacks of sudden physical weakness or paralysis when laughing, angry, or in other emotional situations
0 1 2 3 4 5 have daytime sleep complaints that seem to go in cycles or only appear at certain times (example: only in the evenings; every 10 days; when you sleep away from home)

E) FAMILY SLEEP HISTORY - Do any of your relatives have a sleep disorder? Yes No

Circle all that apply: mother, father, brother, sister, son, daughter

Circle the type of sleep disorder: sleep apnea, narcolepsy, restless legs, insomnia

F) SOCIAL HISTORY - Please complete the following general information.

Circle whichever applies: live and sleep alone, someone sleeps in a room close by, have a roommate, married

What is your occupation ________________________________________________________________

Cups of caffeinated coffee/day _______________ Number of caffeinated drinks/day _______________

Number of cigarettes, cigars or pipe-fulls of tobacco _______________________________________________________________________________/day
Number of years smoking ________________________________________________________________

Number of alcoholic drinks per week ____________________________________________________

G) REVIEW OF SYSTEMS - Please check those issues that apply to you.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>Ear, nose, mouth, throat:</td>
<td></td>
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<tr>
<td>___</td>
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<td>Respiratory symptoms:</td>
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<td>Cardiovascular symptoms:</td>
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<td>Gastrointestinal symptoms:</td>
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<td>Kidney problems:</td>
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<td>Psychiatric issues:</td>
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<td>Neurological problems:</td>
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<td>Musculoskeletal problems:</td>
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<td>Endocrine or gland problems:</td>
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<td>Constitutional symptoms or issues:</td>
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<td>Other</td>
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If there are other physicians you would like to receive a copy of the test results, please list their names, phone numbers, and addresses here: ________________________________