US Sleep PA, LLC

Pottsville Pa 17901
Tel: (570) 581-8218 Fax: (888) 383-2102
www.ussleeplab.com

# Sleep Study Instructions and Information

## Scheduling and Cancellation Policy

An all night sleep study appointment is very different from most health care appointments. A sleep study runs throughout an entire evening and a sleep technician is scheduled to be present for 10 hours to manage the care of only two patients. For this reason, it is vitally important that you keep the appointment that you have scheduled with us. If emergency circumstances dictate that you must reschedule your appointment, we ask that you provide us with as much advance notice as possible. *At a minimum, we require notification on the business day prior to the date of your scheduled appointment.* If you cancel your appointment without the required notice, or if you do not show up for your appointment, we will assess a $150.00 non-refundable cancellation fee. This non-refundable cancellation fee is the responsibility of you the patient and will not be covered by your insurance company.

## *General Instructions*

- Please bring a photo ID to show to our Technician. This is for your safety as well as our technician.
- Please avoid chocolate or any beverages containing caffeine for 12 hours prior to your study.
- Do not take any naps on the day of your study.
- Do not consume any alcoholic beverages the day of your sleep study.
- Please bring a list of your medications with just the name of the medication and milligrams .
- Please come freshly bathed with your hair loose - no braids. Also, please have no hair products in your hair (such as gels, mousse, oils, hairsprays, etc.) and any moisturizers or baby oil on your face or legs.
- If you feel like you may have a difficult time falling asleep during the sleep study, please talk to your doctor about acquiring a prescribed or over the counter sleep aid.
- Do not wear jewelry, other than a watch or rings, as jewelry interferes with the electrical Signals during testing. We prefer no nail polish or acrylic nails as they may interfere with the pulse oximeter.
- Cell phones and pagers must be turned off before the study starts.
- No smoking is allowed inside the facility.
- Please be at the sleep center promptly at **8:30 PM** no earlier, depending on your appointment time. While the technician will arrive at the facility earlier, they will be preparing for your study. You can expect to be awakened between **4:45 a.m. to 5 a.m.** to prepare you for leaving.
- One parent must accompany children under 18 years of age.

*Items to Bring With You* Please bring any personal items that you may need during your time at the sleep center. We will be unable to supply these items for you. In addition, we ask that you bring:

- Pajamas/Something to sleep in
- Toiletries
- Any medications you may need
- Pillow(s) if you think you will sleep better with your own.
- Something to read (optional)
- If you are already using CPAP/ BIPAP machine then bring your mask (Only mask).

In order to avoid potential loss, the possession of personal valuables by patients while at the sleep center is discouraged. In the event that these instructions are not followed by the patient, U.S. Sleep Diagnostic Services will not be responsible for such lost possessions. (Please, do not bring them.) Please notify us prior to testing if you are on home oxygen or have certain health conditions or handicaps.

# Zia H Shah MD and US Sleep Lab

[illegible] Suite 2 [illegible] Pottsville, Pa 17901

**Tel : (570) 581-8218**
Fax: (888) 383-2102

**PHYSICIAN REPORT AUTHORIZATION**

**NAME:**____________________________________________
**DATE:**________________

I hereby give permission for the reports of my Sleep Studies and Office consultation and visits to be sent to the following physicians. **REPORTS CANNOT BE SENT WITHOUT COMPLETE NAMES AND ADDRESSES, INCLUDING ZIP CODE.**

**FAMILY PHYSICIAN:**

________________________________________________
(NAME)
________________________________________________
(ADDRESS)
________________________________________________
(CITY, STATE, ZIP CODE)

**REFERRING PHYSICIAN:**

________________________________________________
(NAME)
________________________________________________
(ADDRESS)
________________________________________________
(CITY, STATE, ZIP CODE)

**ADDITIONAL REPORT:**

________________________________________________
(NAME)
________________________________________________
(ADDRESS)
________________________________________________
(CITY, STATE, ZIP CODE)

**Signature:**__________________________________________
**Date:**____________

# Zia H Shah MD and US Sleep Lab

..., Pottsville, Pa 17901

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**NAME:** ______________________________________ **AGE:** _____
HEIGHT _______ WEIGHT _______

ADDRESS: ____________________________________________________________
____________________________________________________________PHONE:
______________ PRIMARY PHYSICIAN: _________________

## *PAST MEDICAL HISTORY*

If you have any of the following problems please encircle it:

Hypertension
Heart attack
Angina
Irregular heart beat
Congestive heart failure
Stroke
TIA
Gastric reflux
Hiatal hernia
Atrial fibrillation
Emphysema
Sleep apnea
Narcolepsy
Diabetes mellitus
Depression
Asthma
Sinusitis
Hay fever
Any allergy problems
Polycystic ovarian disease
Nasal polyps
Deviated nasal septum
Any ear, nose or throat problem
Seizures
Epilepsy
Tonsillectomy
Adenoidectomy
Any operations

Any other medical disease
____________________________________________________________

## *PRESENT MEDICATION AND DOSAGE (Please enlist prescription as well as over the counter)*

____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

## *ALLERGIES*

Do you have any drug allergies. Yes No
Please describe ______________________________________________

## *PERSONAL HISTORY*

Have you ever regularly smoked? Yes No
If yes how many years have you smoked? ____ years
If yes are you still smoking? Yes No
How many cigarettes did you or do you smoke in an average day: ________
How often on the average do you consume alcoholic beverages?
Once a month or less 2-3 times a week nearly everday
How many caffeinated beverages do you use in a day? ________

### *GENERAL*

What is your main problem regarding sleep, please describe:

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

How long have you had the sleep problem? ____________________________

### *ASSESSING SLEEPINESS*

**A.** How likely are you to doze off or fall asleep in the following situations, in contrast to feeling 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 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

**Situation**

a. Sitting and reading ----------
b. Watching TV ----------
c. Sitting, inactive in a public place ----------
(e.g., a theater or a meeting)
d. As a passenger in a car for an hour without a break ----------
e. Lying down to rest in the afternoon when circumstances ----------
permit
f. Sitting and talking to someone ----------
g. Sitting quietly after a lunch without alcohol ----------
h. Sitting in a car, while stopped for a few minutes in traffic ----------

**B.** Do you feel refreshed in the morning after a usual night sleep. YES NO
**C.** Does sleepiness interfere with your activities during the day. YES NO
If answer to **"C"** is yes please describe: ____________________________

__________________________________________________________

**D.** How often do you have problem throughout the day due to tiredness and fatigue:
Never Occasionally Frequently Almost always

## *PERTAINING TO SNORING AND SLEEP APNEA*

Do you snore? YES NO

Do people complain that you snore? YES NO

Do you episodically stop breathing when you are sleeping? YES NO

When you snore, it is usually: Barely audible Easily heard in bedroom
Disturbs my bed partner Heard even outside the bedroom

All together, how many years have you snored 0-1 years 2-5 years 5-10 years
10 or more years

How often do you awaken with choking or a sensation of not breathing? Never
Occasionally Frequently Almost always

Have you gained more than 5 pounds in the last year? YES NO

How much weight have you gained in the last 5 years? ______________

Do you mostly sleep on your back, side or stomach? ______________
Have you been in a traffic accident or near miss in the last 5 years? YES NO

## *PERTAINING TO MISCELLANEOUS SYMPTOMS*

1. Do you experience morning headaches. YES NO
2. Do you experience sore throat in the mornings YES NO
3. Do you use alcohol to help you sleep at night: Never About once a month
   1-2 times a week Daily

4. Do you use sleeping medication or tranquilizer to help you sleep at night: Never
   About once a month 1-2 times a week Daily

5. Do you experience impotence. YES NO N/A

## *PERTAINING TO INSOMNIA*

How often do you experience any problems falling asleep: Never
Occasionally Frequently Almost always

If you are experiencing problems falling asleep, how long have you had that? ______________

How long does it take you on an average night to fall asleep? ______________

How and when your insomnia problems start? ______________
______________

How many hours do you sleep on average in 24 hours? ______________

What is your usual time of sleep during week days? ______________

What is your usual time of sleep on week ends? ___________________________________

How many and how long naps you take during the day? ____________________

How many times during the night do you go to the bathroom to urinate?

0-1 2-3 3-4 5 or more

How often you have trouble staying sleep: Never Occasionally Frequently Almost always

Do you wake up early in the morning without a desire to do that: Never Occasionally Frequently Almost always

How much caffeine do you consume in form of coffee, tea or cola drinks?

### *PERTAINING TO NARCOLEPSY*

1. Have you ever noted muscle weakness or paralysis when overcome by any emotion like laughter, anger or joy. YES NO

2. Have you ever noted complete paralysis when falling asleep or waking from sleep. YES NO

3. Do you experience vivid dreams when falling asleep or waking from sleep.

   YES NO

### *PERTAINING TO PERIODIC LEG MOVEMENTS*

When you sleep do you disturb your bed partner by twitching or jerking of your arms or legs:

Never Occasionally Frequently Almost always

When falling asleep in the beginning of the night, how often do you experience creepy, crawly or an aching sensation in your legs:

Never Occasionally Frequently Almost always

In the evening hours do you experience an inability to sit still:

Never Occasionally Frequently Almost always

### *REVIEW OF SYSTEMS*

Please circle or mark if you have any of the following symptoms:

| | | | |
|---|---|---|---|
| Fever | Chills | Night sweats | Weight loss |
| Double vision | Red eye | Vision problems | Fainting |
| Post nasal discharge | Blocked nose | Nasal bleed | Sinus problems |
| Angina | Swelling of feet | Irregular heart beat | Chest pain |
| Waking up at night with difficulty in breathing | Cough | Coughing up blood | Shortness of breath |

| Choking on food | Nausea | Vomiting | Constipation |
|---|---|---|---|
| Diarrhea | Difficulty in swallowing | Heart Burn | Pain on urination |
| Urinary Frequency | Frequent headaches | Dizziness | Ministroke |
| Muscle weakness | Osteoporosis | Achiness in calves | Skin rash |
| Anxiety | Depression | Diabetes Mellitus | Thyroid problems |
| Psychiatric problems | Seizures | Received allergy shots | Hay fever |
| Anemia | Easy bruisibility | Palpitation | |

***FAMILY HISTORY***

Is there a family history of sleep apnea or narcolepsy? YES NO

Is there a family history of any heart or lung problems? YES NO

Is there a family history of any other disease? YES NO

If answer to any of the above questions is yes, please describe:

______________________________________________

______________________________________________

***QUESTIONS FOR THE BED PARTNER***

Does your partner snore? YES NO

Does your partner seem to stop breathing during sleep? YES NO

Does your sleep partner jerk his or her limbs in sleep? YES NO

Please include any other information that may be helpful

______________________________________________

______________________________________________

______________________________________________

______________________________________________