Test Preparation for Polysomnography Study

Instructions and Questionnaire

Beaumont® | HEALTH SYSTEM

_____

PATIENT NAME

_____

APPOINTMENT DATE

_____

APPOINTMENT TIME

Call for appointment scheduling changes.
Please bring this with you when you report for your sleep study.

Beaumont Sleep Evaluation Services, Berkley
Beaumont Sleep Evaluation Services, Macomb

AMERICAN ACADEMY OF SLEEP MEDICINE
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SLEEP
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Types of tests administered at the Beaumont Sleep Evaluation Center

Polysomnogram

A Polysomnogram includes a series of sensors and electrodes that are placed on the skin to measure a variety of bodily activities as you sleep. These tests include:

- Electroencephalpgram, or EEG – A EEG measures sleep stages and breathing patterns
- Electromyogram, or EMG – A EMG measures muscular movements in sleep
- Electrocardiogram, or EKG – A EKG measures heart rhythm

The combination of tests helps clinicians to diagnose apneas, other breathing disorders, bruxism (grinding of the teeth), sleep disruptions, periodic limb movement disorder and heart rhythm issues.

PAP Titration

A CPAP or BPAP titration is the treatment portion of sleep-related breathing disorders, the most common of which is obstructive sleep apnea. In addition to all of the tests that are done with a polysomnogram, an additional test monitors the pressure of the positive air pressure delivery device. During the night, technicians adjust the pressure and measure the results, including oxygen saturation and sleep efficiency.

A technologist will teach the patient about the therapy and the devices used for the therapy. A brief trial of the device will take place before the test begins and the therapy will be adjusted for comfort.

Multiple Sleep Latency Test, or MSLT

Used to diagnose or rule out narcolepsy, this test involves a series of five naps at certain intervals during the day, following a PSG or PAP titration study. The PSG/PAP titration is performed to monitor the efficiency and quality of sleep prior to this test.

During the test, naps begin 90 minutes to three hours after the overnight study has ended, take place at intervals of two hours and last between 20-35 minutes. The latency to REM sleep is measured for all naps. A blood and urine test for stimulants may be necessary.

Patients are provided with juice and snacks as well as access to television. Patients are encouraged to bring their own meals (especially with special diets) but simple meals can be provided.

Maintenance of Wakefulness Test, or MWT

MWT measures the ability to stay awake. This test may follow a PSG and consists of four sessions of 40 minutes each recorded throughout the day.

During the sessions, the patient sits in a dimly lit room without any stimulus such as television, music or reading material. The patient should be able to stay awake. The duration of the procedure and the impact of the test may make this stressful to the patients. The staff is trained to handle all questions and issues that may arise.

Patients are encouraged to bring their own meals (especially with special diets) but simple meals can be provided.

Patient information for sleep studies

What is a polysomnogram?

A polysomnogram is a procedure which measures bodily functions during sleep. Each study will vary depending on the individual case and some of the measurements taken may include:

- brain waves (electrodes placed on the scalp)
- heart beats (electrodes placed on the chest)
- eye movements (electrodes placed above and below the eyes)
- muscle tension (electrodes placed on the chin)
- leg movements (electrodes placed on the lower leg)
- airflow breathing (sensor placed underneath the nose)
- chest and abdominal breathing (sensors placed around the chest and abdomen outside of your pajamas)
- blood oxygen levels (a small sensor attached/taped to your finger)

Why record all these things?

During sleep, the body functions are different than while awake. Disrupted sleep can disturb daytime activities and sometimes medical problems during sleep involve a risk to basic health.

How can I sleep with all these things on me?

Surprisingly, most people sleep reasonably well. We are only looking to obtain a sample of your sleep. The body sensors are applied so that you can turn and move during sleep. None of the electrodes break the skin. The entire procedure is painless. Our staff will try to make your sleeping environment as comfortable as possible.

Will the sensor devices hurt?

No. Sometimes, in rubbing the skin or putting on the electrodes, there are mild and/or temporary skin irritations. The technologist will use a medical conductive paste which is easily washed off in the morning with soap and water. You may also feel a sensation of warmth where the oxygen-measuring device contacts the skin of your finger. However, these do not generally cause any significant discomfort.

Will I be given a drug in the sleep lab to help me sleep?

IMPORTANT: NO MEDICATIONS WILL BE DISPENSED ON SITE. PLEASE SEE PAGE 11 FOR FURTHER DIRECTIONS

Your doctor may instruct you to stop taking certain medications before coming for the test. It is also important not to consume any alcohol or caffeinated beverages after 2 p.m. on the day of the testing. Technologists do not have sleeping aids available.

What should I bring?

See preparation instruction on pages 11 and 12.

Is this test covered by insurance?

If you have questions regarding coverage, please call your insurance company.

What happens after the polysomnogram?

On the morning following your test, a preliminary report is sent to the doctor who ordered the test. However, your doctor may decide to wait until he or she receives the final report (in about 10 days) before issuing recommendations. You will also receive instructions the morning after your study from the sleep lab personnel. Technologists do not have test results after test is complete.

Questions about your sleep and wake behavior

Please state in your own words the reason you (or your doctor) contacted the Beaumont Sleep Evaluation Services.

_____

_____

_____

About falling asleep

What time do you usually try to fall asleep? _____ ❑ a.m. ❑ p.m.

How much does your bedtime vary? From: _____ ❑ a.m. ❑ p.m. To: _____ ❑ a.m. ❑ p.m.

How long does it usually take you to fall asleep? _____

How many days a week does it take you more than 30 minutes to fall asleep? _____ never _____ days

When falling asleep or trying to fall asleep, how often do you:

CHECK ONE BOX FOR EACH STATEMENT	NEVER	SOMETIMES	OFTEN
Feel afraid of not being able to sleep?	❑	❑	❑
Have thoughts racing through your mind?	❑	❑	❑
Feel sad, depressed, feel muscular tension or worry about things?	❑	❑	❑
Feel unable to move?	❑	❑	❑
Have creeping, crawling, aching or twitching feelings in your legs (feel like you have to move them)?	❑	❑	❑
Have vivid, dream-like scenes even though you know you are not totally asleep?	❑	❑	❑
Suddenly become aware or alert?	❑	❑	❑

About sleeping

On average, how many hours of sleep do you get each night? _____ hrs.

How many times do you usually awaken each night? _____
Do you have trouble getting back to sleep? ❑ Yes ❑ No

On a typical night, what is your longest period of wakefulness? _____

How long are you awake all together during the night? _____

If you awaken during the night, is it usually during the (check one):
❑ first half of the sleep period? ❑ second half of the sleep period?

Circle any of the following which **frequently** disturb your sleep: choking, gasping, snorting, shortness of breath, heat, cold, light, noise, bed partner, asthma, cough, indigestion, hunger, thirst, need to urinate, chest pain, frightening dreams, getting up to attend to children or something else, creeping-crawling-aching feelings in your legs (like you have to move them), other: _____

_____

What percentage of the night do you think you sleep in each of these positions?
Side: _____ Back: _____ Stomach: _____ Don't know: _____

How often do you:

CHECK ONE BOX FOR EACH STATEMENT	NEVER	SOMETIMES	OFTEN
Snore loudly?	❑	❑	❑
Sleep with someone else in your bed or room?	❑	❑	❑
Feel your heart pounding during the night?	❑	❑	❑
Sweat a lot during the night?	❑	❑	❑
Walk in your sleep?	❑	❑	❑
Fall out of bed while asleep?	❑	❑	❑
Wake up screaming, violent or confused?	❑	❑	❑
Have unusual movements while asleep?	❑	❑	❑
Wet the bed?	❑	❑	❑
Grind your teeth at night?	❑	❑	❑
Has anyone observed that you stop breathing while asleep?	❑	❑	❑

About waking up

What time do you usually have your final awakening? _____ ❑ a.m. ❑ p.m.

How much does your final awakening time vary? From: _____ ❑ a.m. ❑ p.m. To: _____ ❑ a.m. ❑ p.m.

How long do you usually stay in bed following your final awakening? _____

How many days a week do you wake up refreshed and well-rested? _____ days/wk

How often do you:

CHECK ONE BOX FOR EACH STATEMENT	NEVER	SOMETIMES	OFTEN
Wake up confused or disoriented?	❑	❑	❑
Wake up with a headache?	❑	❑	❑
Have a very hard time waking up?	❑	❑	❑
Depend on an alarm clock to wake up?	❑	❑	❑
Fel unable to move when waking up?	❑	❑	❑
Have dream-like images when waking up even though you know you are not asleep?	❑	❑	❑
Wake up one or two hours before you have to get up?	❑	❑	❑
"Sleep-in" in the morning (more than one hour) past your usual wake-up time?	❑	❑	❑

About daytime functioning

How many naps do you take in a usual week? _____

How long do you usually sleep during a typical nap? _____

Are the naps refreshing? ❑ Yes ❑ No

How often do you:

CHECK ONE BOX FOR EACH STATEMENT	NEVER	SOMETIMES	OFTEN
Feel sleepy during the day?	❑	❑	❑
Fall asleep unintentionally? Please give an example: _____	❑	❑	❑
Feel weakness in your muscles when laughing, surprised, angry, excited, etc.?	❑	❑	❑
Have thoughts racing through your mind?	❑	❑	❑
Feel sad, depressed, worry about things or feel muscular tension?	❑	❑	❑

Check the box which indicates how often the following symptoms bother you (0 means never and 6 means all the time or often)	Never ←						→ Often
	0	1	2	3	4	5	6
With regard to performing your most important, usual daily activity (work, school, child care, housework, etc.), how much of the time have you had to push yourself to remain alert while performing this activity?							
In the past month, how much difficulty have you had with concentrating?							
In the past month, how much of a problem have you had with having to fight to stay awake?							
How much difficulty have you had finding the energy to exercise and/or do activities that you find relaxing (leisure activities)?							
How much of a problem has decreased energy been for you?							
How much of a problem has excessive fatigue been for you?							
How much of a problem has it been for you to stay awake while reading?							
How much do ordinary activities require an extra effort to perform or complete?							

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way to 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	**Chance of dozing (indicate 0 - 3)**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (a theater, a meeting, etc.)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

Questions about your family's medical history

Does anyone in your family have sleep apnea, narcolepsy, insomnia, or other sleep problems? ❑ Yes ❑ No

Please provide details:

RELATIONSHIP TO YOU	**DESCRIBE THE PROBLEM**
_____	_____
_____	_____
_____	_____
_____	_____

Does anyone in your family have seizures (convulsions, fits)? ❑ Yes ❑ No

Please provide details: _____

_____

_____

Questions about diet, drugs and medications

How much of the following fluids do you drink during a typical day?

	Total per 24 hours	Within two hours before bedtime
Caffeinated coffee, tea or soda	_____ drinks	_____ drinks
Uncaffeinated coffee, tea or soda	_____ drinks	_____ drinks
Beer, wine or other alcoholic beverages	_____ drinks	_____ drink

Indicate whether or not you have smoked cigarettes, cigars or pipes:

	Current Smoker	Never-Smoked	Ex-Smoker	Year Quit
Cigarettes	❑	❑	❑	_____
Pipe	❑	❑	❑	_____
Cigar	❑	❑	❑	_____

Circle any of the following that you currently use: marijuana, cocaine, hallucinogens (LSD, mescaline, PCP or "angel dust"), depressants ("downers"), stimulants ("uppers"), narcotics. How often? _____

Please list the name and dose (in mg.) of all medications you take **now** or **within the past 30 days**.

MEDICATION AND DOSE	MEDICATION AND DOSE
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medicines or to latex? ❑ Yes ❑ No If yes, list here:

_____

Please list the name of any pill for sleeping or to help you stay awake that you have taken in the PAST.

NAME	DID IT HELP?	NAME	DID IT HELP?
_____	❑ Yes ❑ No	_____	❑ Yes ❑ No
_____	❑ Yes ❑ No	_____	❑ Yes ❑ No

How many times each week do you participate in a sport or partake in some form of exercise?

_____

What is your personal interpretation as to why you have your particular sleep/wake problem? _____

_____

Present height: _____ Present weight: _____ Neck size: _____

Has your weight changed recently? ❑ Yes ❑ No. If yes, explain:_____

Please check any problem or illness you have now or have had in the past:

❑ anxiety	❑ asthma	❑ pacemaker
❑ depression	❑ emphysema	❑ kidney problem
❑ mania	❑ chronic bronchitis	❑ bladder problem
❑ schizophrenia	❑ blood clot in a lung	❑ prostate problem
❑ epilepsy (seizure, convulsion)	❑ blood clot in a leg	❑ heartburn
❑ migraine	❑ hay fever or sinus	❑ ulcers
❑ fainting	❑ allergies	❑ arthritis
❑ dizziness	❑ deviated nasal septum	❑ decreased hearing
❑ heart attack	❑ ringing in the ears	❑ angina
❑ blindness	❑ high blood pressure	❑ diabetes
❑ heart failure	❑ respiratory failure requiring being put on a breathing machine (ventilator)	
❑ heart arrythmia: _____	❑ cancer (where: _____)	❑ other: _____

Surgeries and hospitalizations

Check all that apply and add any that are not on the list.

❑ head injury with loss of consciousness	❑ coronary bypass surgery
❑ tonsillectomy	❑ gastroplasty (gastric stapling)
❑ adenoidectomy	❑ intestinal bypass
❑ nose surgery (indicate type: _____)	❑ liposuction
❑ tracheostomy	❑ hernia repair
❑ UPPP (uvulopalatopharygoplasty–surgery for sleep apnea)	❑ gallbladder removal
❑ other surgery related to the nose or mouth	❑ hysterectomy (removal of uterus or womb)
❑ angioplasty	❑ removal of ovaries

❑ other surgery _____

_____

_____

CPAP history

Have you ever used CPAP or BPAP therapy? ❑ Yes ❑ No **If yes**, how long did you use it? _____ years

Are you currently using CPAP or BPAP therapy? ❑ Yes ❑ No **If yes**, list current pressure setting _____ cm/H2O

Bed-partner/roommate questionnaire

Name of person filling out this form: _____

Relationship to patient: _____

I have observed this patient's sleep: ❑ Never ❑ Once or twice ❑ Often ❑ Every night

Check any of the following behaviors that you have observed this person doing while asleep.

❑ light snoring	❑ loud snoring	❑ occasional loud snorts
❑ choking	❑ pauses in breathing	❑ twitching or kicking of legs during sleep
❑ grinding teeth	❑ sleepwalking	❑ twitching or jerking of arms during sleep
❑ bed wetting	❑ biting tongue	❑ getting out of bed but not awake
❑ crying out	❑ sitting up in bed not awake	❑ awakening with pain
❑ head rocking or banging	❑ apparently sleeping	❑ becoming very rigid and/or shaking even if she or he behaves otherwise

❑ other: _____

What percentage of the night does this person sleep in each of these positions?

Side _____ Back _____ Stomach _____ Don't know _____

Please describe the sleep behaviors checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations? ❑ **Yes** ❑ **No**

If yes, please explain: _____

_____

_____

Test preparation instructions for polysomnogram (PSG)

Outpatient check-in instructions

For Macomb patients: Use Urgent Care entrance. Take elevator to the Lower Level. Ring the doorbell.

For Berkley patients: Someone will meet you at the 1st floor lobby, take the elevator to the lower level.

Test instructions

Hair – Wash your hair prior to coming and do not put spray or oil, etc. on it.

Food – Eat a good meal prior to (PSG), but avoid food that would cause heartburn, acid indigestion. No chocolate.

Drink – No alcohol or caffeinated beverages after 2 p.m. prior to testing because these drinks affect test results.

Medication

- Please bring all medication you may need during your test.
- Please consult the doctor who ordered this test before changing any medication regimen. Ask about discontinuing any medication before your sleep study and when to do so, if appropriate.
- No medications will be dispensed by the staff on site.

Sleep diary – Please complete at home for 14 days prior to testing, if possible.

We will provide towels, shower and toilet facilities.

Do not take naps and avoid heavy exercise on the day of the study.

Checklist of items to bring to the sleep lab

❑ Wear loose comfortable bedtime clothing, such as two-piece pajamas or shorts.

❑ Toothbrush, toothpaste, shampoo and shower soap.

❑ Book to read.

❑ Completed questionnaire/sleep diary.

❑ CPAP machine and mask, if currently using therapy.

❑ On the day of testing, please bring your driver's license and insurance card.

Two-week sleep diary prior to test date

Name: _____ Test date: _____

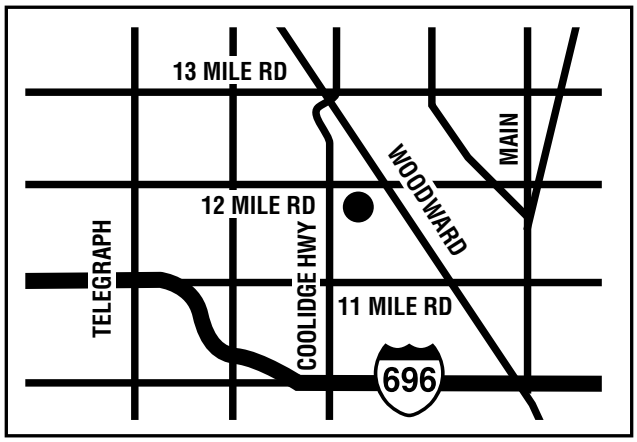
Section I
Complete this section just before bed

DAY/DATE	BEDTIME MOOD 1 - VERY UPSET, 5 - VERY GOOD	MEDICATION TAKEN	TIME LIGHTS TURNED OUT
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

Section II
Complete this section just after awakening

APPROX. TIME TO FALL ASLEEP (MINUTES)	NUMBER OF AWAKENINGS DURING THE NIGHT	FINAL WAKE UP TIME	TOTAL SLEEP TIME	WAKE UP MOOD 1 - VERY UPSET, 5 - VERY GOOD
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				

COMMENTS BY PATIENT:



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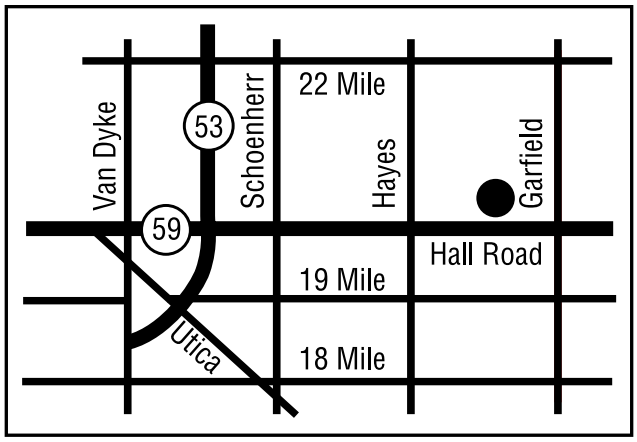

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