Sleep Trends
Diagnostic Centers

What to Expect for Sleep Study

Date/Time:_____ **□ 8:30P □ 9:00P □ 9:30P**

Location: **Mesquite Plano Rockwall**

- **Out of Pocket expense for your sleep study is** $_____
- **Payment for your sleep study MUST be paid BEFORE your study is completed as our sleep technicians DO NOT accept payment at the time of service.**
- **This only an estimate given by your insurance company and is subject to change once claim is processed.**

IF YOU CANCEL and/or NO SHOW WITHIN 24 HOURS you will be charged a fee of $100. If you need to RESCHEDULE, you will be charged a fee of $50.

Preparation

- Please advise SLEEP***TRENDS*** 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.
- Please eat dinner before your sleep study as outside food is not allow within our facility.
- Please complete all paperwork prior to arriving to your sleep study appointment.

What to Bring

- Please bring something comfortable to sleep in.
- Please have your identification, insurance card, and completed paperwork.
- 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)
- Please note, we are not responsible for any items left behind.

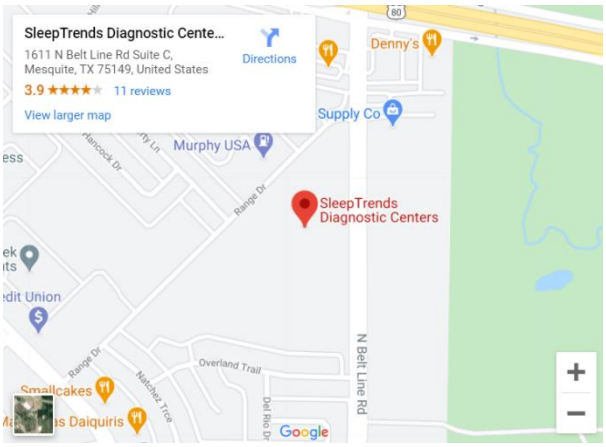
What to Expect

- 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 the following morning, usually between **5 and 6 A.M.**
- After the study, your results will be available within **5 to 7 days**.

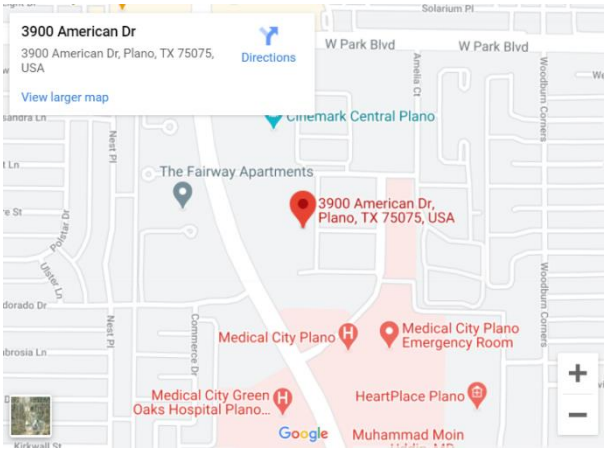
Follow Up Appointment Location: **Mesquite Plano Rockwall**

Date/Time of Follow Up Appointment:_____

Sleep Trends
Diagnostic Centers



1611 N. Belt Line Road Suite C Mesquite TX 75149



3900 American Drive Suite 203 Plano TX 75093

3142 Horizon Rd, Rockwall, TX 75032

Sleep Trends
Diagnostic Centers

Testing Procedure

- Upon arriving, you will be asked to complete a pre-sleep questionnaire and sign a consent form to perform testing.
- 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 (Mesquite).
- Towels will be provided, but please remember to bring your own toiletries.
- A breakfast snack will be available to you to start your day off right.

Results will be forwarded to your physician's office within 5 to 7 business days.

Sleep Trends
Diagnostic Centers

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

□High Blood Pressure □Heart Attack □Tonsillectomy
□Bypass Surgery □Asthma □Headaches
□Seasonal Allergies □Nasal Surgery □COPD
□Nose Fracture □Acid Reflux □Diabetes
□Congestive Heart Failure □Stroke □Sinus Problems
□Other: _____
□Medication Allergies:_____
□Smoking: # of years:_____
Packs Per Day: _____
Current Medications:
Have You Quit: □No □Yes When: _____

1. _____
2. _____
3. _____
4. _____

Recent change in weight: _____

On an average night: Do you or have you ever been told that you:

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?_____

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 sour/bitter taste in mouth? □Yes □No
Hold your breath while you sleep? □Yes □No
Awaken gasping, or short of breath? □Yes □No
Fall asleep unintentionally? □Yes □No
Snore? Since when?_____ □Yes □No

Do you experience any of the following:

□Light Snoring □Snoring interrupted by silence/gasping
□Moderate Snoring □Trouble concentrating
□Loud Snoring □Falling asleep at inappropriate times
□Choking □Short Temper
□Talking in Sleep □Lack of energy
□Sleep Walking □Loss of Libido
□Restless Sleep □Fatigue
Are you experiencing excessive daytime sleepiness? □Yes □

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? _____
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: _____

_____

Sleep Trends
Diagnostic Centers

Signs & Symptoms of Disordered Sleep

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
- ☐ Narcolepsy – 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

Sleep Trends
Diagnostic Centers

Epworth Sleepiness Scale

Name:_____ ☐ Male ☐ Female Date: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Even if you haven't done any of these activities recently, think about 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.

Situation	**Chance of Dozing**
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	_____