

ASSOCIATES IN SLEEP MEDICINE

At the Holy Family Sleep Disorders Center

100 North River Road • Des Plaines, Illinois 60016

Phone 847-297-1800 ext. 2080 • Fax 847-440-9042

Overnight Sleep Test Instructions

Please arrive at the entrance next to the MRI Trailer for your scheduled **8:30 p.m.** sleep study. All patients arrive at 8:30pm. It may be up to 75 minutes before your technologist begins preparing you for your study, therefore you may wish to bring reading materials; cable TV is also available.

LOCATION OF ENTRANCE FOR STUDY:

Entrance is located next to the MRI trailer on the SW portion of the Medical Center, behind the Holy Family Plaza Pharmacy.

Traveling west on Golf Road past River Road, you enter the second entrance. Proceed up the entrance to the ramp where you can park. Walk past the MRI trailer to the entrance. You will check in with the Security Officer. If an officer is not present, a phone is located on the east wall. Pick up the phone and an officer will arrive to assist you.

CANCELLING A SLEEP STUDY:

If you need to cancel your sleep study the same night or notify the technician that you are late please call 847-813-3297; otherwise, to reschedule your sleep study please contact 847-297-1800 Ext. 2080.

IMPORTANT INFORMATION ABOUT PAPERWORK:

1. If you have HMO type insurance, you **MUST** bring your referral with you. If you do not have your HMO referral, we will have to re-schedule your test.
2. If you have a written order from your doctor, please bring it with you.
3. The physician who interprets your test results will bill an interpretation fee, in addition to the cost of the test itself. Holy Family Medical Center will bill for the cost of the test only.
4. Please bring insurance card(s) and a photo I.D.
5. Please complete any attached sleep disorders questionnaires (if applicable) and bring them with you on the night of the test.

PREPARATION FOR YOUR TEST:

1. **AVOID ALCOHOLIC BEVERAGES** on the day of your test, unless otherwise instructed by your physician.
2. **AVOID CAFFEINE** (coffee, soft drinks, chocolate, etc) after 12:00 noon on the day of your test.
3. Do not nap, do not "sleep in" on the day of your test.
4. Bring any medication (prescription or non-prescription such as Tylenol or aspirin) that you may need. The technician will not administer any medication.
5. **IF YOU ARE A DIABETIC**, please bring your medication and any snack that you may need. Food service is not provided.
6. Bring sleepwear. You will not be allowed to sleep in your underwear only, or in the nude.
7. Please wash your hair prior to coming in for your test.
8. The Sleep Center test rooms are similar to hotel rooms. Linens are provided, and you may shower after your test, if desired. Please bring any grooming items you may need.
9. There will be several spots of electrode past on your scalp after the test. This can easily be washed out from your hair in the morning, either at the Sleep Lab or at home.
10. Bring an overnight bag with your necessities.
11. Your test will end approximately between 5:30 and 6:30 a.m., unless your technologist determines that more data are needed or other pre-arrangements have been made. If you must leave earlier, please inform your technologist.
12. If you have any **SPECIAL MEDICAL NEEDS OR NEED ASSISTANCE** with walking, standing, or other daily living activities, please be sure the Sleep Lab staff is informed before your test day.

INFORMATION ABOUT YOUR SLEEP STUDY

1. WHAT IS A POLYSOMNOGRAM (SLEEP STUDY)?

A polysomnogram is a study that measures the quality of your sleep. A typical polysomnogram includes the following measures:

- Brain waves (electrodes placed on the scalp)
- Eye movement (electrodes placed on the face, by the eyes)
- Chin muscle tone (electrodes placed on or near the chin)
- Heart rate (electrodes placed on the chest)
- Leg movements (electrodes placed on the legs)
- Breathing (breathing sensor placed near the nose and mouth)
- Breathing effort (two small elastic belts placed around chest and abdomen)
- Oxygen level (small sensor attached to the finger)
- Audio and video recording

2. WHY IS IT NECESSARY TO RECORD THE ABOVE FUNCTIONS?

During sleep, the body functions differently than while awake. Disturbed sleep, such as irregular breathing or lack of sleep consolidation, can interfere with daytime activities, cause daytime sleepiness, and cause serious health problems.

3. HOW CAN I SLEEP WITH ALL OF THE ELECTRODES?

Most people sleep reasonably well. We are looking to obtain a sample of your sleep pattern. The body sensors are applied so that you can move during sleep and change positions during the night. The sleep rooms are set up as comfortable bedrooms, and our staff makes the environment as restful as possible.

4. WILL THE SENSORS HURT?

No. This is a painless and non-invasive (no needles) testing procedure. Paste is applied to your skin and scalp to keep the electrodes in place, but it is easily removed with soap and warm water.

5. WHAT IS A MULTIPLE SLEEP LATENCY TEST (MSLT)?

Some people also participate in daytime testing. This test consists of a series of 20-minute naps. Sensors and electrodes are used to record information similar to the polysomnogram test. 20-minute naps are taken every two hours throughout the day. Please bring something to read or work on during the day to help keep you occupied in between naps. A DVD player is available. The MSLT test is usually completed by 6:00 p.m.

6. WHAT HAPPENS AFTER MY SLEEP STUDY?

The sleep studies are reviewed by our sleep specialists. Recommendations are made based on this review. A detailed report will be sent to the referring physician in about seven to ten business days.

SLEEP SYMPTOM AND MEDICAL QUESTIONNAIRE

IDENTIFYING INFORMATION

First and Last Name: _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

Gender: _____ Marital Status: _____ Weight: _____ lbs. Height: _____ ft./in.

PRESENTING PROBLEM

Please describe your main complaint by checking one or more of the items below and providing a brief explanation of how you experience these difficulties:

- I have trouble falling asleep
 I'm sleepy all day
 I have unwanted behaviors when I'm asleep

2. Explain: _____

SLEEP SCHEDULE

Please describe your *typical* sleep schedule:

- During the *work week*, you go to bed at: _____ (AM or PM?), rising at: _____ (AM or PM?).
- On *days off/weekends*, you go to bed at: _____ (AM or PM?), rising at: _____ (AM or PM?).
- When do you usually feel at your best? Morning Evening
- How long does it usually take you to fall asleep? _____ (Indicate minutes or hours)
- How many times do you wake up during the night? _____
- How long are you usually awake when waking at night? _____ (Indicate minutes or hours)

HEALTH HABITS AFFECTING SLEEP

- | | Never | Little | Weekly | 2-3 times/wk | Daily |
|--|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. How often do you <i>usually</i> nap? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. How often do you <i>usually</i> exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3a. Do you smoke cigarettes <i>or</i> have you smoked in the past? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| b. If Yes: How long have you smoked? | _____ (Indicate years or months) | | | | |
| c. How much do you smoke each day? | _____ (Indicate cigarettes or packs) | | | | |
| d. If you've quit, when did you stop? | _____ (Indicate years or months) | | | | |
| 4a. Do you drink alcohol? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| b. If Yes, at what time(s), and how much? | _____ | | | | |
| 5a. Do you drink anything with caffeine regularly?
(<i>this includes: coffee, tea, soda/pop, energy drinks</i>) | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| b. If Yes, what do you drink and at what time(s) during the day or night? | _____ | | | | |

SLEEP SYMPTOM DESCRIPTION

Please help us understand the nature of your sleep difficulties. Check all statements that apply:

1. I have been told that I snore loudly.
2. My bed covers are very messed up in the morning.
3. I usually toss and turn at night and am a restless sleeper.
4. I have been told that I kick and poke my bed partner during sleep.
5. My arms or legs move during sleep, sometimes waking me up.
6. I have hallucinations or dreams while falling asleep or waking up.
7. I sometimes awaken with a choking sensation.
8. I have been told that I stop breathing while asleep.
9. I have fallen out of bed.
10. I frequently wake from my sleep at night.
11. I have felt paralyzed or unable to move when waking up.
12. I have felt paralyzed or unable to move when falling asleep.
13. I awaken suddenly feeling fearful, anxious, tense or depressed.
14. When I awaken during the night, I frequently use the bathroom
15. I feel the quality of my sleep is unsatisfactory.
16. I have been told that my arms or legs twitch and jerk during my sleep.
17. I frequently get cramps in my legs.
18. I sometimes wake up with a headache.
19. I have trouble falling asleep at night.
20. I have trouble falling back to sleep when I wake up during the night.
21. Some nights I never get to sleep no matter how hard I try.
22. When I try to go to sleep my mind races with thoughts.
23. I often sleep better in a hotel or at a family member's home.
24. I have had accidents, or near accidents because of being sleepy or falling asleep.
25. The muscles in my legs feel tense, and moving my legs and feet relieves the tension.
26. I feel pain when I try to fall asleep or pain wakes me up at night.
27. I often need to take sleep pills to fall asleep.
28. I have a creeping crawling feeling in my legs when I lie down or relax.
29. I am a very light sleeper, I am awakened easily.
30. My sleep is disturbed because of my bed partner.
31. I have had occasions when I feel sudden weakness in my legs.
32. I can fall asleep at any time, regardless of the situation.
33. I feel that I sleep too much.
34. I feel that I sleep too little.
35. I generally feel sleepy all day.

SLEEPINESS

Please indicate how likely you are to fall asleep in each situation:

	No chance (0)	Slight chance (1)	Moderate chance (2)	High chance (3)
1. Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sitting inactive in a public place (e.g. theater, meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

YOUR MEDICAL CONDITIONS

1. Please indicate if you have, or have had, any of the following conditions?

- | | | |
|---|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Large tonsils or adenoids |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Deviated septum, crooked/broken nose |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Undergoing dialysis | <input type="checkbox"/> Dizziness or passing out |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Anxiety, nervousness or panic attacks |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Large uvula | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Morning headaches | <input type="checkbox"/> Menopause or perimenopause |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Chronic headaches | <input type="checkbox"/> Irritable bowel, ulcers, stomach pain |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer (type): _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other: _____ |

2. Please describe any other medical conditions or current physical complaint: _____

3. Please list all medications that you take.

4. Have you undergone upper airway or sinus surgeries? If yes, please describe Yes No
any surgeries performed on the nose, mouth, throat, neck or head:

5. Please list any allergies: _____

FAMILY HISTORY

Does anyone else in your family have sleep problems? Yes No

If yes, describe their relationship to you (e.g. mother, father, sister) and their condition:

OTHER INFORMATION

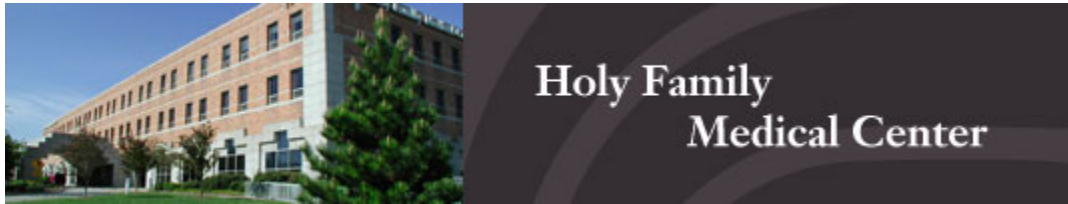
1. Please describe any other information you feel may affect your sleep, or your treatment with us:

Patient Name: _____

Pre-Study Adult Sleep Log

For the week prior to your appointment, please complete the following sleep log **each day** as accurately as you can.

	Sample	Night 1	Night 2	Night 3	Night 4	Night 5	Night 6	Night 7
Indicate date and day of the week:	10/5 Monday							
What time did you get into bed?	10:30 pm							
What time did you get up for the day?	6:30 am							
Approximately how many hours did you sleep last night?	7.5 hrs							
What was the quality of your sleep? (1-5) <small>1 = Very Poor; 2 = Poor; 3 = Fair; 4 = Good; 5 = Very Good</small>	2							
Bed partner's assessment of your sleep:	Loud snoring							
How long did it take you to fall asleep?	5 min							
How many times did you awaken?	5							
Total time awake after sleep onset?	25 min							
List the time and duration of any naps you took during the day?	4:30 pm. (2 hours)							
List any over-the-counter or prescription sleep medication you took last night:	None							
Other information about your sleep:	Tried not to nap, but had to							



ASSOCIATES IN SLEEP MEDICINE

At the Holy Family Sleep Disorders Center

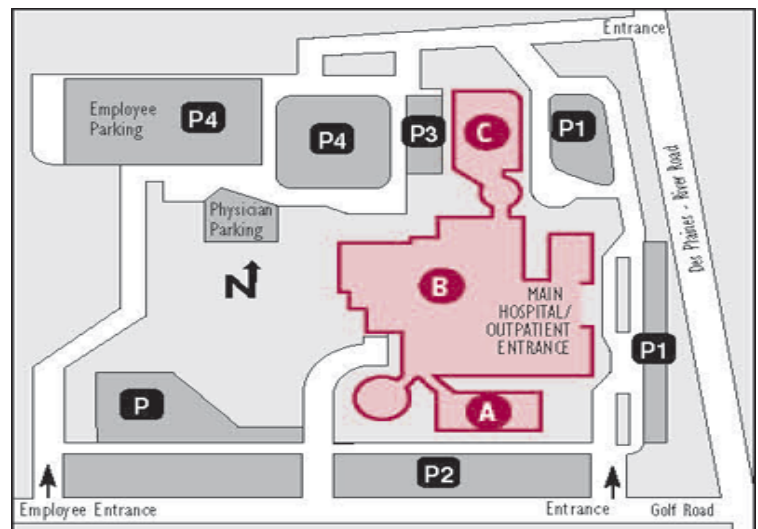
100 North River Road, Floor 4 ♦ Des Plaines, IL 60016 ♦ 847-297-1800 ext. 2080

Driving Directions

- **From Southbound I-294**
 - Take the IL-58 exit toward Golf Road
 - Turn left onto East River Road
 - Turn right onto Golf and proceed through the intersection at River Road
 - Turn right into the hospital parking lot
- **From Northbound I-294**
 - Take the US-14/West Dempster St. exit
 - Merge onto Dempster and immediately make a slight turn right onto Rand Road
 - Proceed to River Road and make a slight turn right
 - Pass through the intersection at Golf Road and turn left into the hospital parking lot
- **From the Northwest**
 - Take either Rand or Northwest Hwy. to Golf Road
 - Turn left onto Golf Road
 - There is an entrance to the parking lot before River Road
- **From the North**
 - Take River Road South (North of Willow Road, Milwaukee Ave. South leads to River Road)
 - Turn right into the parking lot before Golf Road
- **From the South**
 - Take either Mannheim or Des Plaines River Road North (Both roads merge into River Road)
 - Proceed through intersection at Golf Road and turn left into hospital entrance
- **From the East**
 - Take Golf Road West, past River Road
 - Turn right into the hospital parking lot
- **From the West**
 - Take Golf Road East
 - Turn left into the hospital parking lot before the intersection of River Road

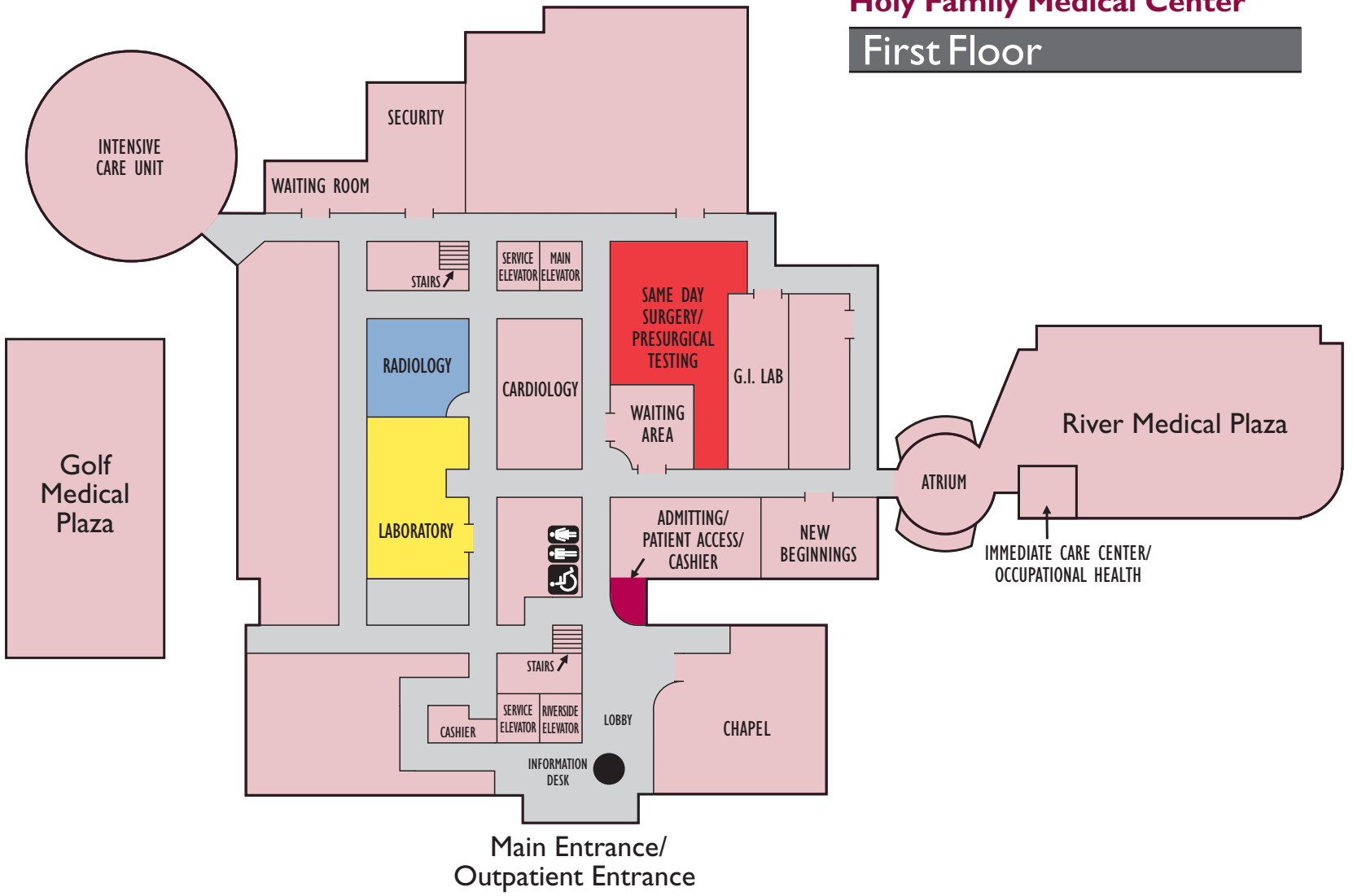
Parking Map

- A** Golf Medical Plaza
- B** Holy Family Medical Center
- C** Immediate Care Center
- P1** Outpatient/Visitor Parking
- P2** Golf Medical Plaza Parking
- P3** River Medical Plaza/ICC Parking
- P4** Additional Parking



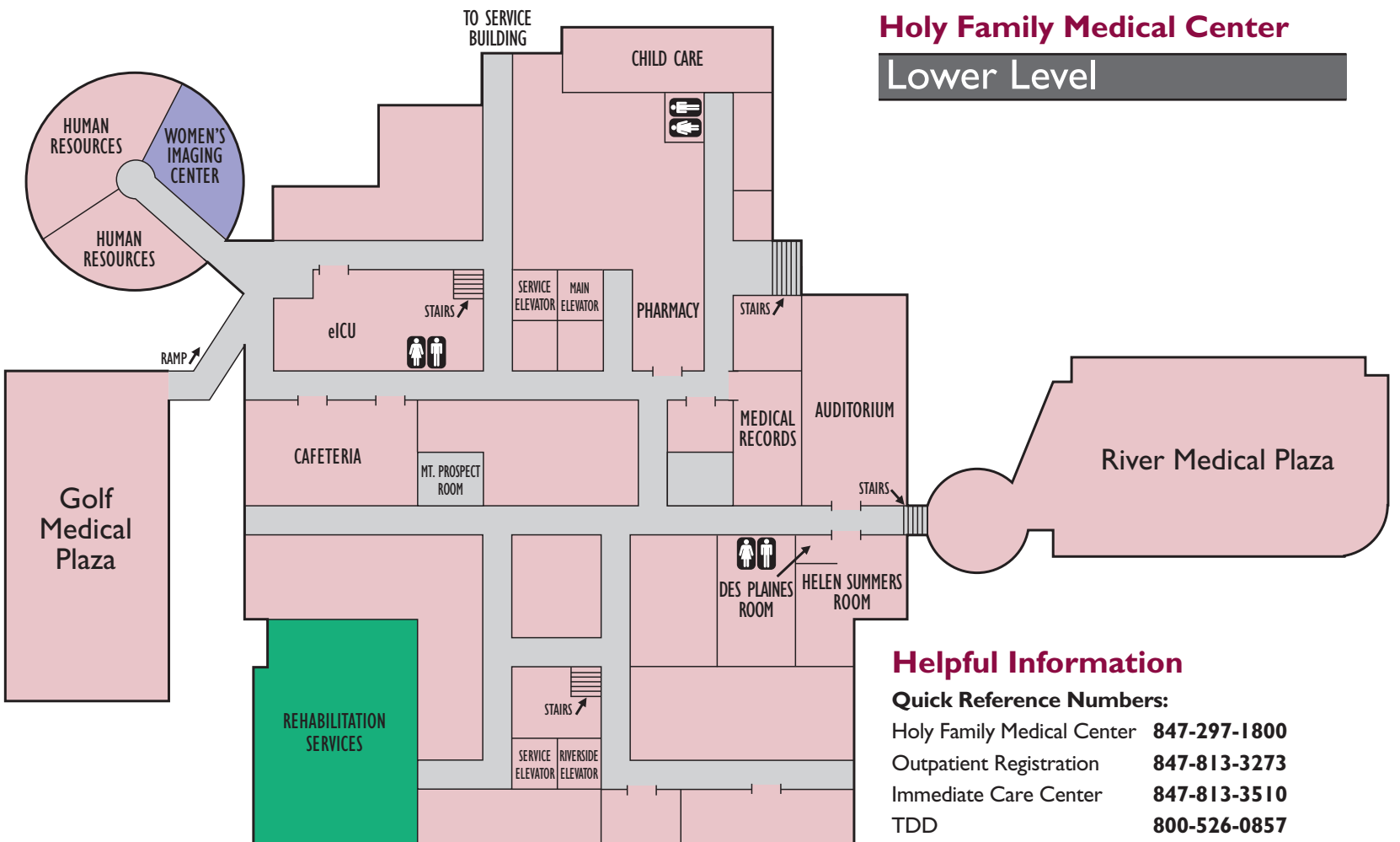
Holy Family Medical Center

First Floor



Holy Family Medical Center

Lower Level



Helpful Information

Quick Reference Numbers:

- Holy Family Medical Center **847-297-1800**
- Outpatient Registration **847-813-3273**
- Immediate Care Center **847-813-3510**
- TDD **800-526-0857**
- Human Resources **847-297-1800, ext. 1146**
- Inpatient Referral Line **847-813-3330**

Nurse Advice • Health Information • Physicians

877-RES-INFO (737-4636)

Please visit our website at hfmc.reshealth.org

We've added color-coded signage in our facility to assist you in finding your destination. The colors on this map correspond with our signage.