SLEEP DIAGNOSTICS, INC

www.sleepwellmt.com
900 N. Montana Ave. Suite A9, Helena MT. Phone: 406-449-8999, Fax 406-449-8989

You have an appointment at Sleep Diagnostics Inc. For an all-night "sleep study"

PATIENT NAME	TIME	DAY OF WEEK	MONTH	DAY OF MONTH

Directions: *We are in the Upper Level of the Professional Plaza on the corner of Missoula Ave. and Montana Ave. One block south of Helena High School and next to Sage Medical Clinic. Park in the upper level parking lot.*

KEEP this first page---please complete all other paperwork and bring with you to the sleep study.

(48 HOURS NOTICE IS REQUIRED TO AVOID A $100.00 CANCELLATION FEE)

******If you are coming due to excessive sleepiness please have someone drive you and pick you up *****

ON THE DAY OF YOUR SLEEP STUDY:

1. Eat meals as usual, but don't drink caffeinated drinks (such as coffee, cola or tea) after 1:00 pm.
2. Please make certain that your hair is clean and DRY. Do not use hair oils such as VO5 or Brillo Cream.
3. Please perform nighttime routine at home: Brush your teeth, Wash your face etc. Do not apply any lotion to your face or legs.
4. Take your medications as instructed by your physician (if you take them right before bed then bring them with you to take at that time)
5. Do not take any naps if possible.
6. For girls: You will need to REMOVE YOUR NAIL POLISH! (don't get your nails done prior to the study or we will have to mess it up ☹)
7. If you have long hair, it would help to loosely braid your hair.

WHAT TO BRING:

1. Bring nightwear to sleep in, (should be 2-piece, cotton is best) (**t-shirt and shorts are ideal)**
2. Bring medications that you take before bed, including any sleep aids, also bring glucose testing if you have it in the event you need to test.
3. Bring your insurance cards, reading material (if you read before bed), snack (if you snack before bed – refrigerator/ microwave is available)

What is a sleep study?

A sleep study is an all-night study designed to provide vital information about your sleeping health by monitoring various signals from your body. These signals include: brain-waves, heart activity, muscle activity, eye movements, breathing patterns and oxygen levels. The signals are obtained from small sensors attached to you scalp, face and body. No needles are used and you should not experience any unusual discomfort. Sleep studies enable physicians to evaluate conditions which occur only during sleep and are non-detectable during a regular office exam. Sleep studies help to identify causes of various sleep-related health disorders and to plan for effective treatment.

What is the procedure during a sleep study?

It will take a sleep technician about 40 minutes to attach small sensors to your head, chest stomach and legs and you will be asked to fill out short pre-sleep questionnaire. After set up you can unwind as usual (read, or watch TV). The tech will monitor you from another room. If you need anything just ask aloud in a normal speaking voice and the tech will come into the room to aid you. You can use the restroom at any time in the night, it is an easy process (urinal or bedside commode is available upon request). If a breathing problem is observed during your study the tech may awaken you to ask you to try a device that treats breathing problems during sleep. Generally the tech will discuss this with you prior to bed. The device is PAP (Positive Airway Pressure) and it includes a small mask that fits over your nose or silicone plugs in your nostrils.

What is the procedure after a sleep study?

It will take approximately 7-9 working days for the study results to get back to your primary care physician. He/She will contact you concerning the results. A copy of the interpretation and a sleep center survey will be mailed to you.

*****BILLING PROCEDURE: There are two parts to a sleep diagnostic testing bill. The technical component is what is performed on the night of your sleep study. A board certified sleep specialist will bill the professional component of the sleep study for his/her interpretation report. (Just like when you have an x-ray. You get a separate bill from the radiologist)**

TYPES OF CARE/SERVICE AVAILABLE

Sleep Diagnostics' offers the following services

- Diagnostic in-facility testing
- Split Night in-facility sleep testing
- Titration in-facility sleep testing
- CPAP titration in-facility testing
- Home sleep testing
- Multiple Sleep Latency Testing
- PAP and supplies for non-Medicare/Medicaid patients
- Nocturnal pulse oximetry testing

CARE and SERVICE LIMITATIONS

Sleep Diagnostics' has the following limitations to care and services

- Weight limit for in-facility testing is 425lbs
- Age criteria is 5yr-90yr (Special considerations if ≥ 3yr or ≤ 95yr must be approved by Medical Director)
- Patient must be able to transfer into and out of bed independently or caregiver must be present
- Patient must be able to perform activities of daily living independently
- Medications are never dispensed by our staff. Patients must come with any medications that they need to take.

HOURS OF OPERATION

Sleep Diagnostics' office hours are Days Mon-Fri 8:00 AM to 5:00 PM Sleep studies are by appointment only Mon-Sun 7:00 PM to 7:00 AM.

CONTACT INFORMATION

Sleep Diagnostics' contact information is as follows:
Phone Number: 406-449-8999 extension 100 Toll Free 1-855-449-8999
Fax Number: 406-449-8989
Website: www.sleepwellmt.com

REFERRAL PROCEDURES

Sleep Diagnostics' has the following referral procedures

- Must be referred by a licensed medical provider, doctor of:
  - Medical or Osteopathy (M.D. or D.O.)
  - Dental surgery or Dental medicine
  - Podiatric medicine
  - Optometry or Ophthalmology
- Exceptions:
  - Non-Medicare/ Medicaid/ Tricare/ United patients may self-refer; however, they must complete a valid sleep screening questionnaire with ESS and FSS prior to scheduling that will be reviewed by the medical director and authorized for sleep testing.
  - These patients MUST be followed up in clinic by the board-certified sleep physician.

CHARGES FOR SERVICES

Sleep Diagnostic will provide a copy of the charges for services time of service.

Clients can call the contact information listed above prior to service and request verbal confirmation of the charges for any services scheduled.

**Please complete this paperwork and bring it with you to your sleep study. You can also email it back to char@sdinc1.net or mail it back to: 900 N. Montana Ave. Suite A9, Helena MT. 59601 Thank you.

Sleep Screening Questionnaire

PLEASE PRINT YOUR NAME *EXACTLY* AS IT APPEARS ON YOUR INSURANCE CARD.
WE WILL NEED A COPY OF YOUR INSURANCE CARD. THANK YOU.

Date _____

Last Name _____ First Name: _____ MI _____ Ms., Mrs. or Mr. _____

Address: _____ City: _____ State _____ Zip _____

D.O.B. _____ Telephone: _____ Cell: _____ Work: _____

SS #: _____ Sex: _____ Ht in inches _____ Wt in lbs _____

Primary Insurance: _____ ID # _____ Grp # _____

Policy Holder Name and DOB: _____

Secondary Insurance: _____ ID # _____ Grp # _____

Policy Holder Name and DOB: _____

NAME OF PRIMARY CARE PROVIDER _____

If Medicaid your **Passport Provider Name**: _____

Name and Relationship of person filling out this questionnaire:

Email Address: _____

List ALL MEDICATIONS and SLEEP AIDS: ******BE SURE TO LIST OXYGEN IF YOU USE IT

Medication	Dosage *Example:: 200mg twice a day*	Times of day that you take it *Example: 8am, 8pm*

*Use the following space to briefly describe your child's sleep problem. If you do not feel that you have a sleep problem, please describe why you believe your doctor has ordered this test and **fully complete** the questionnaire regardless:*

My child's normal bedtime is at: _____

He/She usually get up for the day at: _____

It usually takes him/her _____ minutes to fall asleep

Does your child try to avoid bedtime? ☐ YES ☐ NO

He/She is usually awake _____ # of times in the night

How many hours does your child sleep on an average night? _____ hours

Does your child have access to electronics AFTER lights out? Is there phone, gaming or computer available in the night?

☐ YES ☐ NO If YES, please explain: _____

He/She is usually awake at the following times in the night: _____

If your child wakes up routinely in the night, what are the circumstances? _____

Once settled down, does your child have difficulty falling asleep? ☐ YES ☐ NO

Does your child take naps? ☐ YES ☐ NO

If yes, what time or times? _____ And for how long?

Does your child experience "restless legs" (This may look to you like he/she cannot keep their legs still, or he/she may complain of their legs hurting) ☐ YES ☐ NO

How many nights per week do your child's legs cause difficulty with concentration or cause insomnia? ☐ Nights per week

Is your child current on vaccinations? ☐ YES ☐ NO

Is your child on oxygen? ☐ YES ☐ NO

Has your child had his/her TONSILS REMOVED? ☐ YES ☐ NO

If yes at what age? _____ And by which surgeon? _____

Has your child had his/her ADENOIDS REMOVED? ☐ YES ☐ NO

If yes at what age? _____ And by which surgeon? _____

Have you been told that your child's tonsils are enlarged? ☐ YES ☐ NO

Does your child snore? ☐ YES ☐ NO

If yes, what position does he/she snore in? _____

Has your child ever been on a ventilator? ☐ YES ☐ NO

Was your child born premature? ☐ YES ☐ NO

If yes what gestational age?

Was the birth a normal vaginal birth without complications? ☐ YES ☐ NO

If there were complications please explain: _____

Do any caregivers smoke around the child either in a home or automobile? ☐ YES ☐ NO

Do any blood related parents or grandparents have obstructive sleep apnea? ☐ YES ☐ NO

Has anyone in your family ever died from SIDS (sudden infant death syndrome)? ☐ YES ☐ NO

Is your child a mouth breather when awake?	☐	YES	☐	NO
Does your child frequently have a runny nose?	☐	YES	☐	NO
Do you have any pets?	☐	YES	☐	NO

If yes, please list number and type: _____

Has your child ever been diagnosed with: *(please check any that apply)*

- ☐ Asthma
- ☐ ADD
- ☐ ADHD
- ☐ Bronchopulmonary dysplasia (BPD)
- ☐ Gastroesophageal reflux (GERD)
- ☐ Nasal or sinus allergies
- ☐ Food allergies please list:
- ☐ Other allergies, please list:
- ☐ Down Syndrome
- ☐ Achondroplasia or other dwarfism
- ☐ Developmental delay
- ☐ Cerebral palsy
- ☐ Mucopolysaccaridosis
- ☐ Treacher-Collins Syndrome
- ☐ Pierre Robin Syndrome
- ☐ Prader-Willi Syndrome
- ☐ Sickle cell anemia
- ☐ Spina bifida
- ☐ Autism – Please describe severity:
- ☐ Other syndrome or disorder, Please list: _____

Regarding your child's behavior ***when asleep,*** please check all that apply:

☐	Demonstrates excessive movement during his/her sleep							
☐	Sleep walking	Frequency:	☐	nightly	☐	weekly	☐	monthly
☐	Sleep talking	Frequency:	☐	nightly	☐	weekly	☐	monthly
☐	Has nightmares	Frequency:	☐	nightly	☐	weekly	☐	monthly
☐	Has night terrors	Frequency:	☐	nightly	☐	weekly	☐	monthly
☐	Snores	Frequency:	☐	nightly	☐	weekly	☐	monthly
☐	Bedwetting	Frequency:	☐	nightly	☐	weekly	☐	monthly
☐	Grinds teeth	Frequency:	☐	nightly	☐	weekly	☐	monthly
☐	Holds breath or appears to stop breathing							
☐	Lips turn blue							
☐	Struggles to breathe or appears to have difficulty breathing							
☐	Is a mouth breather when asleep							

Is your child allergic to any medications?	☐	YES	☐	NO

If yes please list: _____

Is your child allergic to any tapes, latex, dyes or metals?	☐	YES	☐	NO

If yes please list:

Parental Instructions for the Pediatric Patient

An overnight Sleep Study is many times difficult for adult patients. For this reason we like to touch base with parents to set some guidelines for the sleep study. We try to get the test done properly so repeat testing is not necessary. Technicians will do their best to work with you and your child, but to have a successful outcome and easy night for your child we would like parents to consider the following:

1. Be optimistic about the night ahead. Negative terminology such as "I don't think he/she can do this" or "I can't believe you expect him/her to sleep like this" are comments that will have a negative influence.
2. Lights out for your child is the same bed time for you. If your child or the technician wants you in the room, you will have a recliner to sleep in. Many times, parents' snoring, kicking, and other activities change the outcomes of the study. For this reason, we rarely allow parents to sleep IN child's bed during testing. Your tech will let you know if you need to leave the room and sleep in the spare room if you are disruptive to your child.
3. Watching TV, talking on the phone, leaving the room repeatedly (and re-entering) are all disruptive to your child's sleep.
4. Please do not allow your child to nap the day of the study.
5. Be sure to discontinue or add medications as instructed by his/her doctor. Failure to do so may result in rescheduling of the test. On a case-by-case basis many doctors will remove stimulant medications from your child for up to a week prior to testing.
6. Bring anything and everything along with your child that will make him/her more comfortable. This includes blankets, stuffed animals, books, favorite pajamas-all are welcome and encouraged. Bring a change of pajamas as well as extra diapers/pull-ups if your child is prone to wetting the bed.
7. Remember to take care of yourself! You are sleeping here as well so you will need your usual medications and pajamas along with anything else for the night. You will not be permitted to leave your child in the sleep center unattended if you forget something.
8. We are happy to do an orientation in the sleep center with your child. We will give them a tour and show the equipment used for testing to you both, as well as answer any questions you or your child may have.
9. Rarely, we are unable to get a child to cooperate with the hookup or testing as the night progresses. None of the equipment is optional. If your child has trouble or gets very upset, testing may be stopped. If this is the case, you may need to leave the sleep center in the middle of the night. Please be prepared for this by driving yourself. We are unable to let your child sleep if testing is not taking place.
10. Your child will have paste in his/her hair in the morning and will need to bathe before school or other activities. Please arrange for this as there is not a shower available in the sleep center.
11. <u>IMPORTANT</u>: You should have been provided with a nasal cannula for "practice" with your child at home prior to the sleep study. (15 minutes a day) If you did not get this please call so we can make sure you have one. Children really hate anything in their nose and it helps so much to desensitize them to the feeling of the nasal cannula prior to the study.

SLEEPDIARY

Good sleep is important for the health and happiness of every person, no matter how old or young. Without getting enough sleep, it can be hard to stay awake, pay attention, and enjoy the day.

Did You Know?

Getting enough sleep helps you stay healthy, safe, and feeling good.

A good night's sleep will help...

* You remember what you learned all day.
  You have more energy for sports and playing.
* Your body fights germs and illness better.
* You to pay attention.
* You feel better about yourself

Tips To Help You Get A Good Night's Sleep

Do:

* Sleep 10 to 11 hours (ages 5-12) every night.
* Go to bed at the same time every night.
  Follow a bedtime routine by doing the same relaxing activities every night before bed - like reading or listening to quiet music.
* Exercise during the day.
  Have a light snack or warm glass of milk before bed if you are hungry.
  Keep your bedroom cool, dark, and quiet.

Do Not:

Stay up late.

* Go to bed at different times each night.
* Watch TV or play video games because they can disturb your sleep.
  Exercise too close to bedtime (3 hours or sooner).
* Drink soda or eat chocolate because they contain caffeine, which can make it hard to sleep.
* Have TV's, computers, video games, loud noises, or bright lights in your bedroom. They can bother you while you sleep.

This **Sleep Diary** is a fun way to help you, your parents, and your doctor talk about the importance of sleep. Each day you will answer several questions about your sleep. Starting any day of the week, fill out the sleep diary for seven days. The last page has an activity for the end of the week.

Have Fun!!!!

_____,Sleep Diary

(Write your name here)

Fill in these blanks with your information.

I am_____years old and in_____grade.

This is the week of _____ _____ _____

(Month) (Dare) (Year)

1. Complete Before Going to Bed

- **What did you drink today?**

In the space inside the space of each day, write the number of cans/bottles of caffeinated drinks, such as soda, and tea or energy drinks that you had each day of the week. Remember, caffeine in drinks can keep you from sleeping well.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

- **Check off any of these activities you did in the HOUR before going to bed.**











	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Read a book							
Used the Computer							
Played with Toys/Games							
Exercised Played Sports							
Watched TV							
Played Video Games							
Listened to Music							
Had a snack							
Took a Bath/ Shower							
Talked on the Phone							
Did Homework							

2. Complete When you Wake Up!

• How did you sleep?

Answer the first two questions by circling YES or NO. Writ e your answer to the last question.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Did you have trouble falling asleep?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Did you wake up during the night?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Who or what woke you up during the night?							

• How much sleep did you get last night?

Color in the boxes from the time you fell asleep lase nigh t until the time you woke up this morning. Count the number of boxes you colored in to figure out how many hours you slept. Write the number of hours you slept below each day.

EXAMPLE	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
7:30 PM	7:30 PM	7:30 PM	7:30 PM	7:30 PM	7:30 PM	7:30 PM	7:30 PM
8:00 PM	8:00 PM	8:00 PM	8:00 PM	8:00 PM	8:00 PM	8:00 PM	8:00 PM
8:30 PM	8:30 PM	8:30 PM	8:30 PM	8:30 PM	8:30 PM	8:30 PM	8:30 PM
9:00 I'M	9:00 PM	9:00 PM	9:00 PM	9:00 PM	9:00 PM	9:00 PM	9:00 PM
9:30 PM	9:30 PM	9:30 PM	9:30 PM	9:30 PM	9:30 PM	9:30 PM	9:30 PM
10:00 PM	10:00 PM	10:00 PM	10:00 PM	10:00 PM	10:00 PM	10:00 PM	10:00 PM
10:30 PM	10:30 PM	10:30 PM	10:30 PM	10:30 PM	10:30 PM	10:30 PM	10: 30 PM
11:00 PM	11:00 PM	11:00 PM	1 1:00 PM	11:00 PM	11:00 PM	11:00 PM	11:00 PM
11:30 PM	11:30 PM	11:30 PM	11:30 PM	11:30 PM	11:30 PM	11:30 PM	11:30 PM
12:00 AM	12:00 AM	12:00 AM	12:00 .\M	12:00 AM	12:00 AM	12:00 AM	12: 00 AM
12:30 AM	12:30 AM	12:30 AM	12:30 AM	12:30 AM	12:30 AM	12:30 AM	12:30 AM
1:00 AM	1:00AM	1:00 AM	1:00 AM	1:00 AM	1:00 AM	1:00 AM	1:00AM
1:30 AM	UOAM	1:30 AM	1:30 AM	1:30 AM	1:30 AM	1:30 AM	1:30 AM
2:00 AM	2:00 AM	2:00 AM	2:00 AM	2:00 AM	2:00 AM	2:00 AM	2:00 AM
2:30 AM	2:30AM	2:30 AM	2:30 AM	2:30 AM	2:30 AM	2:30 AM	2:30 AM
3:00 AM	3:00 AM	3:00 AM	3:00 AM	3:00 AM	3:00 AM	3:00 AM	3:00 AM
3:30 AM	3:30 AM	3:30 AM	3:30 AM	3:30 AM	3:30 AM	3:30 AM	3:30 AM
4:00 AM	4:00AM	4:00 AM	4:00 AM	4:00AM	4:00 AM	4:00 AM	4:00AM
4:30 AM	4:30AM	4:30 AM	4:30AM	4:30 AM	4:30 AM	4:30 AM	4:30 AM
5:00 AM	5:00 AM	5:00 AM	5:00 AM	5:00AM	5:00 AM	5:00 AM	5:00 AM
5:30 AM	5:3 0 AM	5:30 AM	5:30 AM	5:30 AM	5:30 AM	5:30 AM	5:30 AM
6:00 AM	6:00AM	6:00 AM	6:00 AM	6:00 AM	6:00 AM	6:00 AM	6:00 AM
6:30 AM	6:30 AM	6:30 AM	6:30 AM	6:30 AM	6:30 AM	6:30 AM	6:30 AM
7:00 AM	7:00 AM	7:00 AM	7:00 AM	7:00 AM	7:00 AM	7:00 AM	7:00 AM.
7:30 AM	7:30AM	7:30 AM	7:30 AM	7:30 AM	7:30 AM	7:30 AM	7:30 AM
8:00 AM	8:00 AM	8:00 AM	8:00 AM	8:00 AM	8:00 AM	8:00 AM	8:00 AM
8:30 AM	8:30 AM	8:30 AM	8:30 AM	8:30 AM	8:30 AM	8:30 AM	8:30 AM
9:00 AM	9:00 AM	9:00 AM	9:00 AM	9:00 AM	9:00 AM	9:00 AM	9:00 AM
9:30 AM	9:30 AM	9:30 AM	9:30AM	9:30 AM	9:30 AM	9:30 AM	9:30 AM
10:00 AM	10:00 AM	10:00 AM	10:00 AM	10:00 AM	10:00 AM	10:00 AM	10:00 AM
I slept 11 hours.	I slept _____ hours.	I slept _____ hours.	I slept _____ hours.	I slept _____ hours.	I slept _____ hours.	I slept _____ hours.	I slept _____ hours.

3. *Complete at the End of the Day*

- How did you feel during the day?

Color in the boxes up to the number that describes how you felt each day.

- How much energy did you have today?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Full of energy 5							
4							
Some energy 3							
2							
No energy 1							

- How awake were you today?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Wide Awake 5							
4							
Awake but a little sleepy							
2							
Very sleepy 1							

- How did you do in school today?

		Monday	Tuesday	Wednesday	Thursday	Friday
Paid attention in all my classes	5					
	4					
Paid attention some of the time	3					
	2					
Couldn't pay attention	1					

Answer these questions by circling YES or NO

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Did you fall asleep when you didn't mean to?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Did you take a nap?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

4. Complete at the End of the Week!

Use your completed Sections 2 and 3 for this Section. In Part A, think about the day you had the **least** number of hours of sleep this week. In Part B, think about the day you had the **most** hours of sleep. In the blank box in each part, draw or write how you felt on that day.

A. Day with LEAST Hours of Sleep

- On_____(write the day of the week),

I had____ hours of sleep.

1 2 3 4 5

No Energy **Full of Energy**

- Draw or write how you felt

B. Day with MOST Hours of Sleep

- **On** _____ (write the day of the week),

I had____ hours of sleep.

1 2 3 4 5

No Energy **Full of Energy**

- Draw or write how you felt

- **Think about your results.**
  - Did you feel different on the two days?
  - If so, why do you think you felt different?
  - Which day did you feel better?

When you are finished filling out your sleep diary, bring it to your next doctor 's appointment so you can talk about sleep with your doctor.

National Sleep Foundation

To learn more about sleep, visit our website at **www.sleepfoundation.org**