Night and Day Sleep Services – Staten Island
1 Teleport Drive, Suite 200A Staten Island, NY 10314
www.nightanddaysleep.com

Fax to: 914-333-5925
Attn: Sleep Referral Coordinator
Tel: 914-333-5813

Date: _____

Dear Mr./Mrs./Ms. _____

Dr. _____ has scheduled you for overnight sleep study on **_____ at 8:30 PM.** You may park in the visitor parking lot at no charge.

Be sure to bring your insurance information with you. While we check your insurance coverage we ask that you call your insurance company to verify your coverage. You will be responsible for any deductible and/or co-payment at the time of registration.

On the night of your appointment, please bring all medications you are currently taking. A light snack if desired, sleepwear, toiletries, and any reading material you would prefer. To contact the lab directly in case of last minute questions call 347-825-3952.

Our available procedure time is **VERY** limited. With our backlog of patients needing procedures, we believe it is not fair to other patients when a procedure time goes unused. Please try to give us at least 48 hours if you find it necessary to cancel or reschedule an appointment. This way we can fill the time with another patient who has been waiting for this important medical care.

If canceling your appointment is necessary we ask that you notify us at least 48 hours in advance to avoid a $100 cancellation fee. If you have any questions concerning the testing procedure or how to complete the enclosed forms, please call the Sleep Referral Coordinator at 914-333-5813 and our staff will assist you.

Cordially yours,

Sleep Referral Coordinator

Reminder: We require 48 hours notice of any appointment change or cancellation.

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ENCLOSURE

SLEEP LABORATORY PATIENT INSTRUCTIONS TO BE DONE ON THE DAY OF YOUR APPOINTMENT

As natural body oils and normal dirt affect the functioning of the equipment used to perform this test, the following instructions must be carried out on the day of your scheduled appointment.

FAILURE TO FOLLOW THESE INSTRUCTIONS MAY RESULT IN THE CANCELLATION OF YOUR TESTING:

1. **COMPLETE SHOWER OR BATH:**

2. **WASH HAIR WITH SHAMPOO ONLY:** Please no conditioners, hairdressing cream, oils, gels, or hairspray are to be used after your hair has been washed.

3. **HAIR AND SCALP MUST BE COMPLETELY DRY:** upon arrival at the sleep lab otherwise testing will be delayed.

4. **FOR MEN:** Please shave before coming in for your sleep study. This will help keep the sensors in place. If you have a beard please trim it is as much as possible before your study.

5. **FOR WOMEN:** If you wear makeup, please wash off before coming in for your sleep study. Do not wear nail polish on your pointer finger as it may interfere with pulse oximeter reading.

ADDITIONAL INSTRUCTIONS INCLUDE:

6. **FRESH NIGHT CLOTHES:** Garments should be of a cotton or cotton-blend material. A loose fitting top such as a T-shirt or pajama with a button down front and loose fitting bottoms such as shorts, sweat pants, or pajama pants is recommended. Room temperature must be maintained between 65-68 degrees for testing, bring nightclothes that will be comfortable for you under these conditions. You may bring reading material if you desire. Television is available but NOT during testing.
7. **NO ALCOHOLIC OR CAFFEINATED BEVERAGES AND NO FOODS CONTAINING ALCOHOL OR CAFFEINE FOR AT LEAST 6 HOURS BEFORE TESTING:** Alcohol and caffeine consumption will cause disruption of sleep cycles and therefore alter test results so please avoid foods and beverages that contain them on the day of your appointment. If you require a snack at night before bedtime please bring one with you, since we are an outpatient facility we do not have food service available.

8. **PLEASE AVOID BRINGING VALUABLES TO THE FACILITY ON THE NIGHT OF YOUR SLEEP STUDY.**

9. **PLEASE BRING THE FOLLOWING ENCLOSED FORMS COMPLETED ON THE NIGHT OF YOUR STUDY:**

    - Pre-test Questionnaire
    - Sleep Diary
    - Epworth Scale
    - Partner Questionnaire (if applicable)
    - Pediatric Questionnaire (if applicable)

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"What do I need to bring for the sleep study?"
An overnight bag. We recommend loose fitting clothing. **For women:** we recommend a two piece pajama set. Please note that we provide pillows and blankets at the sleep lab but you may bring the following items to make your stay more comfortable; favorite pillow/blanket reading material, teddy bear. **Please take any medications before coming into lab. If you must take medication at night, please bring medications in their original containers. If you are an asthmatic, remember to bring your inhalers.**

"Do I need to do anything differently the day of the test?"
Follow your normal routine and try to eat your meals as you normally eat and take your normal medications. We do ask that you avoid alcohol and caffeine at least 6 hours before the test. If you shave, shave your beard regularly, we also ask you shave before you arrive.

"Where do I go once I get to the sleep lab?"
Enter through the security gates. Free parking is available beyond these gates.
Make a right into Corporate Commons. The lab is on the 2nd Floor in Building 1 through the double doors. Suite # 200-A. Please go down the hallway. Lab is all the way round the corridor.

"What if I can't sleep?"
We do not expect you to sleep just the same way that you do at home but our technicians work hard to create an environment that is as friendly and comfortable as possible. We need a minimum of two hours of sleep time to make a diagnosis but ideally six hours of sleep data is desired.

"What if I have a hair piece?"
If you have a hair piece it is important that you share this information with sleep referral coordinator at time of scheduling. If the technician cannot get to the scalp we won't be able to perform sleep study. Electrodes need to be placed on scalp in order for us to properly diagnose you.

"What time will I be awakened?"
The technologist will wake you between 5:30AM and 6:00AM.

"Who do I call if I have questions?"
Please call the Sleep Referral Coordinator @ **347-825-3952.**

"Who do I call if I arrive at the lab and find the doors locked?"
Please call Dimitri Elibert @ 914-879-2053 or Nausheen Ahmed @ 845-287-2426.

"Who do I call for the results of my sleep study?"
Please wait at least two weeks before calling your doctor for the results of your sleep study.

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Directions:

By car from Brooklyn and Queens NY:
Take I-278 W (Portions toll).
Take EXIT 6 toward South Ave
Merge onto Goethals Rd N
Turn left onto South Ave. Turn slight right.
Take the 1st left onto Teleport Dr.
1 Teleport Drive is on the right. (Corporate Commons)
(Same building as Lavelle charter School)
Take elevator to 2nd floor and doorway to the left hallway.
Sleep Lab is at the end of the hallway- on the left side.

By car from NJ via Outer Bridge crossing:
Take 287 South to 440 North .
Merge onto NY 440N/W Shore Expressway N towards I-278/Staten Island Expwy
Take the South Ave- **Exit- 8**
Turn Rt onto South Ave
Turn Right on Teleport Dr
1 Teleport Drive is on the right. (Corporate Commons)
(Same building as Lavelle charter School)
Take elevator to 2nd floor and doorway to the left hallway.
Sleep Lab is at the end of the hallway- on the left side.

By Car from NJ via Goethals Bridge:
Take 278 E towards Goethals Bridge
Merge onto Forest Ave via **Exit 4**
Forest Ave becomes Gulf Ave
Turn Left onto Edward Curry Ave
Turn slight right
Take 1st left to Teleport Dr.
1 Teleport Drive is on the right. (Corporate Commons)
(Same building as Lavelle charter School)
Take elevator to 2nd floor and doorway to the left hallway.
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MR No. _____
Patient Account: _____

PRE-TEST QUESTIONNAIRE

These questions are necessary for the physician to evaluate your test and must be filled out prior to your appointment. If you are not sure how to answer a question it can be discussed with the technician at the time of your test. Do not alter your normal routine or make any adjustments in medications that you have been using for sedation, sleep or to maintain wakefulness. Please do not consume alcohol or caffeine on the day of your test.

NAME: _____ DOB: _____

ADDRESS: _____

_____ PHONE _____

Emergency Contact _____PHONE_____

Referring MD _____ PHONE_____

Reason for Study_____

SEX_____ HEIGHT_____ Feet. _____Inches WEIGHT_____lbs NECK SIZE_____Inches

What was your weight: 6 months ago _____ 2 years ago_____ At age 20 _____
What was your heaviest weight _____

MEDICAL CONDITIONS (check if present)

____High Blood Pressure	____Heart Disease	____Heart Attack
____Congestive Heart Failure	____Kidney Disease	____Asthma
____Emphysema	____Bronchitis	____Diabetes
____Thyroid Dysfunction	____Seizures	____Stomach Problems
____Chronic Headaches	____Depression	____COPD
____Obesity (Mild/Moderate/Severe)	____Ear, Nose, Sinus or Throat Problems	
____Deviated Septum	____Claustrophobic	

Other _____

MEDICATIONS:

1._____	2._____	3._____	4._____
Frequency: _____	_____	_____	_____
Dosage: _____	_____	_____	_____

Use back of page for additional meds.

ALLERGIES _____

Have you ever had a Sleep Study done? YES _____ NO _____

If YES, where and when was it performed? _____

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Sleep Center Pre-Test Questionnaire

NAME_____ DATE_____

1. Do you feel you get too little sleep at night? YES_____ NO_____

2. Do you feel that you get too much sleep? YES_____ NO_____

3. What time do you normally go to bed? _____
   a. How long are you in bed before you decide to go to sleep? Hours_____ Minutes____

4. Do you have difficulty falling to sleep? YES_____ NO_____
   a. How long does it usually take to fall asleep? Hours_____ Minutes____

5. Do you wake up during the night? YES____ NO_____
   a. How often do you wake up on an average night? Number of times_____

6. What time do you normally wake up in the morning? _____
   a. How do you normally wake up? Spontaneously___Alarm Clock ___ Other ___

7. Do you usually wake up before you need to? YES____ NO_____
   a. If yes, how much earlier do you wake up than is necessary? Hours_____Minutes____

8. Do you feel well rested after you sleep? YES____ NO_____
   a. How difficult is it for you to awaken and get out of bed after sleeping?
   Very difficult_____ Difficult____ Sometimes Difficult_____ No Problem____

9. Do you usually feel fatigued during the daytime? YES____ NO_____
   a. If YES, how often? Rarely_____ Occasionally ____ Frequently ____
   b. Do you find yourself falling asleep when you don't want to? YES___ NO_____
   c. Does fatigue make it difficult to do your daily activities? YES___ NO_____
   d. Do you experience drowsiness while driving? YES___ NO_____
   e. If yes, is it during: short distance driving____ long distance driving____

10. Do you take naps during the day if your situation permits? YES___ NO_____
    a. If yes, how many times during the day do you nap? _____
    b. On the average, how long do your naps last? Hours____Minutes____
    c. Do you feel rested after you take a nap? YES___ NO_____

11. Do you have a regular bed partner? YES___ NO_____

12. Are you aware of, or have you been told that you Snore while you are asleep? YES___ NO___
    a. If yes, how long has this occurred? Years____ Months_____
    b. Is it worse when you sleep on your: Back_____ Side_____ Stomach____
    c. Does your snoring ever wake YOU up? YES____ NO_____
    d. Does it disturb someone in another room? YES____ NO_____

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Sleep Center Pre-Test Questionnaire

NAME_____ DATE_____

13. Are you aware of or have you been told that you:
    a. Stop breathing or breathe irregularly in sleep? YES_____ NO_____
    b. Are you a restless sleeper, tossing, turning often? YES_____ NO_____
    c. Have arm or leg movements during sleep? YES_____ NO_____
    d. Wake up gasping, choking or short of breath? YES_____ NO_____
    e. Wake up with palpitations or irregular pulse YES_____ NO_____
    f. Talk in your sleep? YES_____ NO_____
    g. Grind your teeth in your sleep? YES_____ NO_____
    h. Wake up with indigestion or acid stomach? YES_____ NO_____
    i. Wake up feeling confused? YES_____ NO_____

14. Do you have sleep irregularities related to your work? YES_____ NO_____
    a. Do you work nights/evenings? YES_____ NO_____
    b. Do you rotate shifts? YES_____ NO_____

15. Do you experience headaches? YES_____ NO_____
    a. If yes, how often do they occur? ____Rarely ____Occassionally ___Frequent
    b. Do they occur in the morning when you wake up? YES_____ NO_____
    c. Do they wake you up from sleep? YES_____ NO_____

16. Do you ever experience arm or leg sensations prior to falling asleep or when you wake up?
    a. Pain or cramping? YES_____ NO_____
    b. Restless sensation? YES_____ NO_____
    c. Crawling sensation? YES_____ NO_____
    d. Twitching or jerking? YES_____ NO_____
    e. If yes, does it cause you difficulty in falling asleep? YES_____ NO_____
    f. Does it wake you up during the night? YES_____ NO_____
    g. Does anything relieve the sensation (i.e. getting out of bed, walking, massage, medication)?
    _____
    h. How many times a week does this occur? _____

17. What positions do you tend to sleep in?
    On right side____ On left side____ On back____ On stomach____

18. How many pillows do you sleep with? 1____ 2_____ 3_____ More_____

19. Do you use any breathing aid for sleep? YES____ NO____
    a. Do you use a CPAP or BIPAP breathing machine when you sleep? YES____ NO____
    b.. If yes, what is the setting? _____
    c. Do you use oxygen at home? YES____ NO____
    d. If yes, what is the setting? _____

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Sleep Center Pre-Test Questionnaire

NAME_____ DATE_____

20. Have you ever used any medications, prescription or non-prescriptions to:
    a. Help you sleep? YES____ NO____
    b. Help you stay awake during the day? YES____ NO____

21. Does anyone in your family have any sleep related problems? YES____ NO____
    a. If yes, how are they related to you? _____
    b. What is their problem? _____

22. Do you have any problems with:
    a. Nasal Congestion YES____ NO____
    b. Nasal Obstruction YES____ NO____
    c. Nasal discharge YES____ NO____
    d. Nasal Polyps YES____ NO____
    e. Sinuses YES____ NO____
    f. Tonsils YES____ NO____
    g. Adenoids YES____ NO____
    h. Difficulty Swallowing YES____ NO____
    i. Lump or obstruction in your throat YES____ NO____
    j. Change in your voice within the last year YES____ NO____
    k. Thyroid Condition YES____ NO____

23. Have you ever had any of the following surgeries:
    a. Tonsillectomy YES____ NO____
    b. Adenoidectomy YES____ NO____
    c. Nasal Surgery YES____ NO____
    d. Sinus Surgery YES____ NO____
    e. Vocal Cord Surgery YES____ NO____

24. Do you consume alcohol? YES____ NO____
    a. If yes, how often? Occasionally/Socially____ Weekends____ More Often _____
    b. On an average, how many alcoholic beverages consumed per week? _____

25. Do you smoke? ___Yes ___No a. Cigarettes ____packs per day
    b. Cigars ___per day c. Pipe ____per day

26. Do you consume caffeine? ___Yes ___ No ___ Servings per day

PSG Study Date:_____/_____/_____ PSG Sleep Clinician_____
PSG Study scored by_____ Date:_____/_____/_____
Reviewed by_____ MD Interp._____

Circle one below:
Split/CPAP/OAT- Titration/ Pap Nap Study Date: ____/____/____ Sleep Clinician:_____
Scored by _____ Date:_____/_____/_____
Reviewed Study by: _____ MD Interp._____

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SLEEP CENTER **EPWORTH SLEEPINESS SCALE**

Name:_____ Appointment Date: _____ & Time ____p.m.

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 of life in recent activities. 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

****PATIENT** (please complete)**

SITUATION	0	1	2	3
Sitting and Reading				
Watching TV				
Sitting, inactive, in a public place				
Passenger in a car for an hour without a break				
Lying down to rest in the afternoon				
Sitting and talking to someone				
Sitting quietly after lunch with no alcohol				
In a car, while stopped for a few minutes in traffic				

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SLEEP CENTER SLEEP DIARY

Name: _____ Appointment Date:_____ & Time _____p.m.

The purpose of this form is to provide us with your typical sleep habits. Please start filling it out daily, a week prior to your scheduled sleep study. If your study is less than a week away, give us as many days as you can. This will aid us in the diagnosis of your condition.

Complete the top box each evening prior to bed, and complete the bottom box each morning when you get up. If there is an unusual event on a given night (e.g. illness, emergency, phone calls) make a note of it in the "Unusual Events" row.

- Are you a shift worker yes □ no □ If yes, what hours do you work? _____
- How many pillows do you usually sleep with? _____

DATE	**Example 9/30**							
Each nap time if any	**11am 3pm**							
Total sleep during Each nap time	**15min 1 hr**							
Meds or alcohol taken as a Sleep aid at bed time (Y or N)	**Y**							
Bedtime	**11pm**							

How long did it take you to Go to sleep?	**1 hr**							
Rise time	**6am**							
Total sleep during night	**5hrs**							
Number of Night-time Awakenings	**4**							
Duration of each Awakening	**5, 15, and 25 mins**							
When I awake, I feel 1= exhausted – 5=refreshed	**3**							
My sleep last night was: 1= very restless – 5=refreshed	**2**							
Unsual Events	**Phone call at 1am**							