Date: ____________________

Dear ________________________

Dr. _________________ has scheduled you for overnight sleep study on ______________ at 8:45 PM. Please call the admitting office at 914-366-3075 to pre-register. Please note: Monday – Friday appointments, please use the main entrance and report to the admitting department located on the first floor to pick up your registration papers. If your appointment is scheduled on a Saturday, please use the west entrance and report to the admitting department located on the ground floor to pick up your outpatient registration papers. You may park in the visitor parking lot at no charge.

Be sure to bring your insurance information with you. While we also check your insurance coverage we suggest that you contact your insurance company to verify your insurance 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 914-366-3754 or 914-366-3755.

If this is your first sleep study with night and day sleep services please be sure to fill out the enclosed forms and BRING THEM WITH YOU ON THE NIGHT OF YOUR APPOINTMENT. These documents are necessary for the total evaluation of your test.

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 cancellation of your study becomes necessary, please call the Sleep Referral Coordinator at (914) 366-3626 at least 3 working days prior to your scheduled appointment.

Cordially yours,

Sleep Referral Coordinator
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, hair dressing creams, 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 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)
Night and Day Sleep Services
Phelps Memorial Hospital Sleep Disorders Diagnostic Center
701 North Broadway, Sleepy Hollow, NY 10591
www.nightanddaysleep.com

Frequently Asked Questions:

“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 can 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 whatever food you normally eat and take your normal medication. We do ask that you avoid alcohol and caffeine at least 6 hours before the test. If you shave your beard regularly, we ask you to shave before you arrive.

“Where do I go once I get to the hospital?”
Go to admitting and they will arrange for you to be taken to the sleep lab.

“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 with sleep disorder breathing.

“What time will I be awakened?”
The technologist will wake you between 5:30AM and 6:00AM. A continental breakfast is available.

“Who do I call if I have questions?”
Please call the Sleep Referral Coordinator @ 914-366-3626.

“Who do I call for the results of my sleep study?”
Please call your doctor for the results of your study, at least two weeks from the date of your sleep study.
Directions:

**From the East**
Take the Cross Westchester Expressway (287 West) to Exit 3, the Sprain Brook Parkway North.
Take the Sprain, which becomes the Taconic State Parkway (follow the signs towards Albany).
Take the first exit off the Taconic, Pleasantville-Route 117.
Continue west 3 miles; the road will become Rockwood Road.
At this point, the entrance to the hospital will be on the left.

**From the South**
Take the Major Deegan North into the New York State Thruway (Route 87N).
Take Exit 5, Central Park Avenue (Route 100N) and proceed north two miles (2 lights).
Turn left onto the Sprain northbound.
Continue north on the Sprain 13 miles (pass Route 287) which becomes Taconic State Parkway (follow the signs towards Albany.)
Take the first exit off the Taconic, Pleasantville-Route 117.
At the end of the ramp, turn left at the traffic light onto Route 117.
Continue west 3 miles; the road will become Rockwood Road.
At this point, the entrance to the hospital will be on the left.

**From the West**
Cross the Tappan Zee Bridge.
Take the first exit, Route 9.
Make a right at the end of the ramp onto Route 9 North.
The hospital is 4 miles north on the left.

**From the North (Peekskill area)**
Take Route 9 South.
The hospital is 13 miles south on the right.

**From the North (Yorktown area)**
Take Taconic State Parkway South.
Take the Pleasantville Rd exit toward Pleasantville.
Turn right onto Pleasantville Rd.
Take Route 100 South (also Route 9A South)
[entrance on right from Pleasantville Rd]
Take right onto Route 117 South
[exit on left from Route 100 South]
Follow Route 117 South to the end.
Turn left into hospital parking lot.

**From the Northwest (Brewster or Mt. Kisco)**
Take 684 South
Merge onto Saw Mill Parkway South.
Take exit 5 toward Route 117 South.
Take exit 29, Route 117 South toward Plsntvlle
Turn left onto Route 117 South
Follow Route 117 South to the end.
Turn left into hospital parking lot.
Sleep apnea is a common sleep disorder characterized by brief cessations in breathing during sleep. The two most frequent symptoms of sleep apnea are loud snoring and excessive daytime sleepiness; morning headaches and awakening with a dry mouth or sore throat are also signs of sleep apnea.

In most cases, sleep apnea occurs when the throat muscles and tongue relax and partially block the opening of the airway during sleep. Though an individual continues their efforts to breathe, air cannot easily flow into or out of the nose and this results in heavy snoring, arousals, and periods of no breathing.

There are two types of sleep apnea: central and obstructive.

- Central sleep apnea
  Central sleep apnea is characterized by a cessation or decrease in breathing during sleep. Individuals sustain several awakenings during the night, sometimes with a gasp for air. Additionally, individuals experience circulatory complications, including irregular heartbeats, pulmonary hypertension, and heart failure. Snoring may occur, though it is not prominent.

- Obstructive sleep apnea
  Obstructive sleep apnea, the more common of the two, is characterized by the muscles in the walls of the throat relaxing while the person sleeps so that the walls collapse on themselves and obstruct the flow of air. After about 30 seconds, the obstruction is relieved and breathing resumes. Symptoms of obstructive sleep apnea intensify with increased body weight and blood pressure.

Individuals who believe they suffer from sleep apnea should first contact their primary care physician for a diagnosis. With the proper diagnosis, patients can begin testing and treatment, usually at a sleep center or lab. There are several treatment options available, and therapy is customized for the individual. Behavioral changes, including weight loss, changes in sleeping devices, and the avoidance of alcohol and sleeping pills, are suggested for mild cases. The most common treatment for more severe sleep apnea cases is continuous positive airway pressure (CPAP). The CPAP device is a mask that provides pressure from a blower that forces air and prevents airway closure. Dental devices are a less cumbersome alternative to CPAP, and are designed to move the jaw forward and subsequently open air passages. Additionally, surgical procedures that improve sleep apnea and snoring by enlarging air passages are options for individuals.

The American Academy of Sleep Medicine is a professional organization dedicated to advancing sleep health care by setting clinical standards for the field; advocating for recognition, diagnosis and treatment of sleep disorders; educating professionals dedicated to providing optimal sleep health care; and fostering the development and application of scientific knowledge.

© AASM 2003
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? ______

<table>
<thead>
<tr>
<th>DATE</th>
<th>Example 9/30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each nap time if any</td>
<td>11am, 3pm</td>
</tr>
<tr>
<td>Total sleep during Each nap time</td>
<td>15min, 1 hr</td>
</tr>
<tr>
<td>Meds or alcohol taken as a Sleep aid at bed time (Y or N)</td>
<td>Y</td>
</tr>
<tr>
<td>Bedtime</td>
<td>11pm</td>
</tr>
</tbody>
</table>

| 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 |
| Unusual Events | Phone call at 1am |
RULES OF SLEEP HYGIENE

Proper sleep hygiene has 4 components:

I. Behavior

RULE 1: Have a regular schedule.
*Go to bed and wake-up at the same times, regardless of the day of the week.*

RULE 2: Have a relaxing pre-sleep routine.
*Engage in a routine prior to sleep in order to prep the mind/body for sleep.*

RULE 3: Ensure bedroom only used for sleep or intimacy.
*Only go to bed when drowsy. Do not eat, watch TV, or read in bed.*

RULE 4: Limit the time you spend awake in bed.
*If you are awake in bed for 15-20 minutes, get up and leave bedroom. Engage in quiet activity until drowsy.*

RULE 5: Avoid naps.
*Only nap if necessary to retain alertness (30 minutes maximum). Avoid napping 6-8 hours prior to sleep.*

II. Environment

RULE 6: Have a dark bedroom.
*Avoid bright lights, because bright lights can stimulate awake-sensors in eyes.*

RULE 7: Set cool temperature (or comfortable temperature).
*Uncomfortably warm bedrooms disrupt sleep.*

RULE 8: Avoid/minimize loud noises.
*Use ear plugs or “white noise” machines to minimize loud noises.*

RULE 9: Have a bedroom free of potential allergens.
*Allergens can disrupt sleep because of sneezing, sniffing, and coughing.*

III. Diet

RULE 10: Avoid caffeine 6-8 hours before sleep.
*Chocolate, some teas, coffee contain caffeine. Reasonable daily amount of caffeine is 1-2 cups of coffee.*

RULE 11: Avoid alcohol 3-5 hours before sleep.
*Alcohol may help sleep onset, but sleep will be fragmented and poor quality.*

RULE 12: Avoid nicotine prior to sleep.
*Withdrawal symptoms can disrupt sleep.*

RULE 13: Eat a light carbohydrate snack prior to sleep.
*Hunger can disrupt sleep. Avoid large meals prior to sleep. Avoid sugars and caffeine.*

IV. Exercise

RULE 14: Exercise regularly.
*Regular exercise promotes a regular sleep/wake schedule. The body likes a routine.*

RULE 15: Avoid strenuous exercise 3-5 hours before sleep.
*Exercise raises body temperature. During sleep body temperature lowers, and increased body temperature confuses the mind/body of the regular sleep/wake schedule.*
Your Sleep Study
What to expect

1. Patient arrives
2. Electrode application
3. Head electrodes
4. Body electrodes
5. Lights out
6. Tech monitors patient
7. Patient sleeping
8. Lights on
9. Patient leaves
Thank you for choosing Phelps Memorial Hospital Center for your healthcare needs.

After receiving care at Phelps it is possible that you will receive multiple bills.

- There is a hospital charge for technical services that may include medications and supplies used during your stay in addition to cost associated with the preparation of films.

- A second fee is charged for professional services from an anesthesiologist, cardiologist, emergency room physician, hospitalist, pathologist, sleep study or radiologist. This fee is for the professional portion of your bill.

In order to assist you with any questions you may have pertaining to these bills please refer to the list below.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>MAILING ADDRESS</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td>Westchester Anesthesiologists, PC</td>
<td>914-428-5454</td>
</tr>
<tr>
<td></td>
<td>800 Westchester Avenue S 614</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rye Brook, NY 10573</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Phelps Cardiovascular PC</td>
<td>203-775-6659</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 2149</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Danbury, CT</td>
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<tr>
<td></td>
<td>06813</td>
<td></td>
</tr>
<tr>
<td>ER Physicians</td>
<td>Phelps Memorial Hospital Emergency Physicians</td>
<td>800-666-2455</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 13700-1365</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philadelphia, PA 19191-1365</td>
<td></td>
</tr>
<tr>
<td>Hospitalist</td>
<td>Phelps Memorial Professional Services</td>
<td>212-563-2627</td>
</tr>
<tr>
<td>Pathology</td>
<td>Phelps Memorial Professional Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P. O. Box 95000-3465</td>
<td></td>
</tr>
<tr>
<td>Sleep Study</td>
<td>Phelps Imaging</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>Phelps Imaging</td>
<td>914-819-5347</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 7046</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yonkers, NY 10710</td>
<td></td>
</tr>
</tbody>
</table>
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? _____________________________________________
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? YES_____ NO______
   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? YES_____ NO______
   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______
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  ____Occasionally  ____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? __________________________
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._______________________

Split/CPAP Titration Study Date:_____/_____/______  Split/Titration Sleep Clinician:________________________
Split/Titration Study Scored by______________________________ Date:_____/_____/______
Reviewed Split/Titration____________________________ MD Interp.____________________
**Personnel**

Our friendly and professional staff

---

**Sleep Referral Coordinator**
- Schedules studies
- Primary patient contact person

**Sleep Technician**
- Conducts sleep study
- Monitors patient at night

**Respiratory Therapist**
- Handles CPAP application

**Scoring Technician**
- Scores sleep study

**Director**
- Reviews sleep study

---

**Physician**
- Credentialed (MD)
- Interprets sleep study
- Provides diagnosis

---

Contact our friendly sleep referral coordinators if you have any questions.

(914) 333-5813
**QUESTIONNAIRE**

Please check the appropriate box regarding your relationship to the patient

<table>
<thead>
<tr>
<th>Relationship</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SPOUSE</td>
<td>○</td>
</tr>
<tr>
<td>PARTNER</td>
<td></td>
</tr>
<tr>
<td>ROOMMATE</td>
<td></td>
</tr>
<tr>
<td>PARENT</td>
<td></td>
</tr>
</tbody>
</table>

Please check which of the following behaviors you have observed the patient doing while asleep

<table>
<thead>
<tr>
<th>Behavior</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Loud Snoring</td>
<td>○</td>
</tr>
<tr>
<td>Light Snoring</td>
<td></td>
</tr>
<tr>
<td>Flailing of arms and legs</td>
<td>○</td>
</tr>
<tr>
<td>Twitching of legs and feet</td>
<td></td>
</tr>
<tr>
<td>Breathing pauses (10 sec or more)</td>
<td>○</td>
</tr>
<tr>
<td>Grinding teeth</td>
<td></td>
</tr>
<tr>
<td>Sleep talking</td>
<td>○</td>
</tr>
<tr>
<td>Sleepwalking</td>
<td></td>
</tr>
<tr>
<td>Bed Wetting</td>
<td>○</td>
</tr>
<tr>
<td>Sitting up in bed while asleep</td>
<td></td>
</tr>
<tr>
<td>Rocking or banging of head</td>
<td>○</td>
</tr>
<tr>
<td>Getting out of bed while asleep</td>
<td></td>
</tr>
<tr>
<td>Tongue biting</td>
<td>○</td>
</tr>
<tr>
<td>Becoming very rigid and/or shaking</td>
<td></td>
</tr>
</tbody>
</table>

How long have you been aware of these sleep behaviors? _______________________________

______________________________________________________________________________

Please describe in further detail these observed sleep behaviors: _____________________

______________________________________________________________________________
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.

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<thead>
<tr>
<th>SITUATION</th>
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<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td>Sitting and Reading</td>
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<td>Watching TV</td>
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<td>Sitting, inactive, in a public place</td>
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<td>Passenger in a car for an hour without a break</td>
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<td>Lying down to rest in the afternoon</td>
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<td>Sitting and talking to someone</td>
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<td>Sitting quietly after lunch with no alcohol</td>
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<td>In a car, while stopped for a few minutes in traffic</td>
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**PATIENT** (please complete)