Date: ________________

Dear ___________________

Dr. ____________________ has scheduled you for overnight sleep study on __________ at 8:30 PM. Please report to the admitting department located next to the front lobby to pick up your outpatient registration papers. You may park your car in the visitor parking lot on Davis Avenue at no charge. Please present the parking stub to the admitting department when registering and they will give you a parking voucher to present to the parking attendant so that you don’t have to pay for parking on the way out.

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 914-681-1165.

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.

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.

If cancellation of your study becomes necessary, please call the Sleep Referral Coordinator at (914) 333-5813 at least 3 working days prior to your scheduled appointment.

Cordially yours,

Sleep Referral Coordinator

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

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

“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 @ 914-333-5813.

“Who do I call for the results of my sleep study?”
Please call your doctor for the results of your study.

Reminder: We require 48 hours notice of any appointment change or cancellation.
Night and Day Sleep Services
White Plains Hospital Sleep Disorders Diagnostic Center
Davis Avenue @ East Post Road White Plains, NY 10601
www.nightanddaysleep.com

Directions:

From the North
Take Route 684 South to Route 287, White Plains. Follow Route 287 to Exit 8W, Westchester Avenue. Continue on Westchester Avenue and turn left onto Bloomingdale Road and then right onto Maple Avenue (the next major intersection between Fortunoff and Neiman Marcus). Travel for 6/10 of a mile (9 traffic lights) and make a right onto Davis Avenue.

From the West
Take the New York State Thruway South to Exit 8 (Cross Westchester Expressway-Route 287 East). Take Exit 8W (White Plains). After exiting, turn left and cross traffic into right hand lane on Bloomingdale Road. At first light, turn right onto Maple Avenue. Travel for 6/10 of a mile (9 traffic lights) and make a right onto Davis Avenue.

From the South and East
Take the New England Thruway to Exit 18B, Mamaroneck Avenue, towards White Plains. Continue on Mamaroneck Avenue to Maple Avenue. Turn left. Travel for 3/10 of a mile (4 traffic lights) and make a right turn onto Davis Avenue.

From the South
Take the Hutchison Parkway Exit 23N Mamaroneck Avenue (NOT MAMARONECK ROAD) and follow signs for White Plains. Continue on Mamaroneck Avenue to Maple Avenue. Turn left. Travel for 3/10 of a mile (4 traffic lights) and make a right turn onto Davis Avenue.

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

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.
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</th>
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<tbody>
<tr>
<td>Each nap time if any</td>
<td>11am</td>
</tr>
<tr>
<td></td>
<td>3pm</td>
</tr>
<tr>
<td>Total sleep during Each nap time</td>
<td>15min</td>
</tr>
<tr>
<td></td>
<td>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                        | 3    |
| 1= exhausted – 5=refreshed                  |
| My sleep last night was:                    | 2    |
| 1= very restless – 5=refreshed              |
| 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
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? ___________________________________________

________________________________________________________________________________

________________________________________________________________________________

Page 1 of 4
Sleep Center Pre-Test Questionnaire

<table>
<thead>
<tr>
<th>Name: _____________________________</th>
<th>Date: _____________________________</th>
</tr>
</thead>
</table>

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]
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_____
   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.__________________________

Page 4 of 4
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
- Licensed (RT, RTT)
- Handles CPAP application

Scoring Technician
- Scores sleep study

Director
- Licensed (RT, RTT)
- 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
SLEEP CENTER PARTNER QUESTIONNAIRE

Patient name: ____________________________  Today’s Date: ____________

QUESTIONNAIRE

Please check the appropriate box regarding your relationship to the patient

SPOUSE □  PARTNER □  ROOMMATE □  PARENT □

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

Loud Snoring □  Light Snoring □

Flailing of arms and legs □  Twitching of legs and feet □

Breathing pauses (10 sec or more) □  Grinding teeth □

Sleep talking □  Sleepwalking □

Bed Wetting □  Sitting up in bed while asleep □

Rocking or banging of head □  Getting out of bed while asleep □

Tongue biting □  Becoming very rigid and/or shaking □

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.

Use the following scale to choose the most appropriate number for each situation:

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td><strong>PATIENT</strong> (please complete)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sitting and Reading</td>
<td></td>
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<td></td>
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<tr>
<td>Watching TV</td>
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<td></td>
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<tr>
<td>Sitting, inactive, in a public place</td>
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<tr>
<td>Passenger in a car for an hour without a break</td>
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<tr>
<td>Lying down to rest in the afternoon</td>
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<tr>
<td>Sitting and talking to someone</td>
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<tr>
<td>Sitting quietly after lunch with no alcohol</td>
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<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
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</tbody>
</table>
Your CPAP Application

What to expect

1. Tech explains CPAP
2. Airway open
3. Airway closed
4. Airway reopened
5. CPAP device
6. Patient inhales
7. Patient exhales
8. Patient sleeping
9. Lights on