19455 Deerfield Avenue
Suite 206
Leesburg, VA 20176
Phone: 703-858-9608
Fax: 703-858-9618

1860 Town Center Drive
Suite 270
Reston, VA 20190
Phone: 703-318-8157
Fax: 703-318-7525

Pulmonary and Critical Care Associates

SLEEP DIAGNOSTIC CENTER

Patient Information for Sleep Studies

Location:

1860 Town Center Dr. Ste 270 Reston, VA 20190

___Diagnostic Sleep Study_____at 8:30 PM*

___CPAP Titration Study (NPSG with CPAP)_____at 8:30 PM*

*Please do not arrive before your scheduled time of 8:30PM. *Technicians arrive around 8:00PM.*
If you have someone picking you up please make sure they arrive between 5:00AM and 5:30AM.

WE UNDERSTAND THAT UNFORSEEN CIRCUMSTANCES MAY ARISE, HOWEVER DUE TO THE UNIQUE SCHEDULING DIFFICULTIES INVOLVED IN AN OVERNIGHT SLEEP STUDY WE **REQUIRE** A 48-HOUR NOTICE OF CANCELLATION IN ORDER TO AVOID A ***$250.00*** CANCELLATION CHARGE.

Dear Patient:

You have been referred to our office for an overnight sleep study.
This test will allow us to monitor your sleep and breathing in order to determine which, if any, sleep disorder you may have. This is a non-invasive diagnostic test and we would like to make it as much like a regular night's sleep as possible.

The appointment made for you has been done so in conjunction with your insurance company's requirements. It is important for you and our personnel that you keep your scheduled time. Please contact us **no later than 48 hours prior to your appointment** to reschedule should an emergency arise.

Please read the **Information about sleep apnea and treatment options**. It should answer most of the questions you may have regarding the testing procedures.

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Instructions for the Day of Your Test

1. Avoid taking naps if possible.
2. Avoid caffeine after 10:00AM (includes soda, tea, chocolate and coffee) No alcohol before study.
3. Hair and skin should be clean and oil free. Hair should be loose. Please no weaves or braids.
4. Take your usual medications unless otherwise instructed by your physician. If taking a sleep aid, the technologist will advise when to take it. You may want to bring nasal spray if you're coming in for the CPAP titration.
5. Bring comfortable sleeping attire (do not wear silk). Wear loose fitting two piece pajama sets or shorts and a loose fitting t-shirt. Do not wear anything tight around the ankles.
6. NO OUTSIDE BEDDING Due to health reasons, we do not allow the use of pillows and blankets from outside the lab.
7. Please bring your insurance card so we can verify our billing information.
8. Please complete the medical history questionnaire included and bring it with you the night of your sleep study.

Please be advised that the technician performing your study may be a male. If there is an issue with this, please call the scheduling office at 866-327-3600 to make other arrangements.

How to gain access to the building:

Reston: 1860 Town Center Dr., Ste. 270, Reston, VA 20190

Please do not arrive at the lab before 8:30PM unless you are willing to wait. The sleep tech will come down to the front of the building at 8:30PM to bring patients up to the sleep lab. Do not try to enter from the rear of the building. The sleep tech will wait until 8:45 for any patient who may be running late. If you arrive after 8:45 you must call the sleep tech at 571-490-3640 so the technician can let you in.

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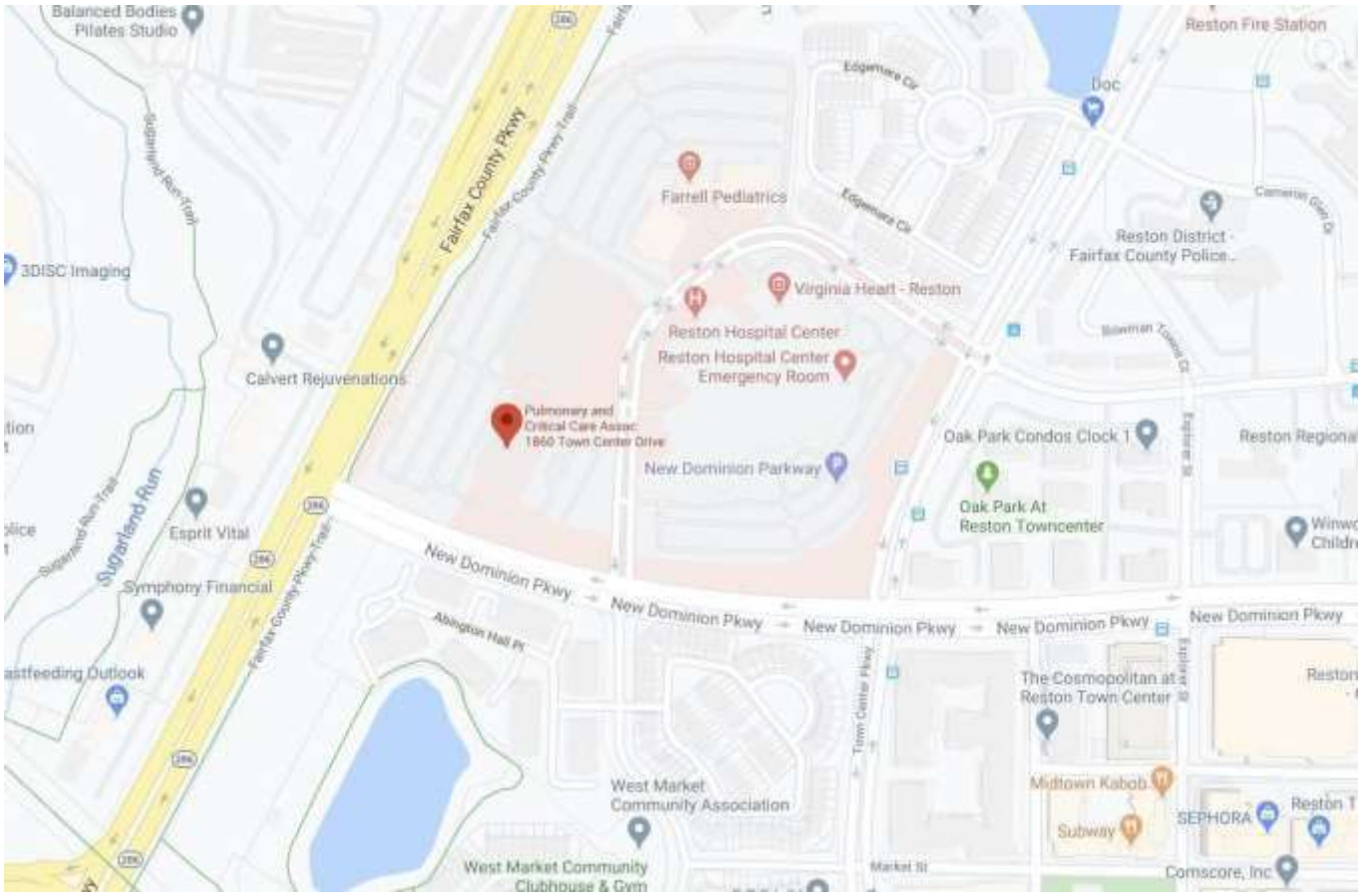
Reston: The lab is located on the campus of Reston Hospital



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Patient Rights and Responsibilities

Pulmonary and Critical Care Associates Medical Staff have adopted the following list of patient rights and responsibilities. This list shall include, but is not limited to, the following:

Patient Rights:

- You have the right to considerate and respectful treatment
- You have the right to receive treatment without discrimination as to race, religion, sex, national origin, or source of payment.
- You have the right to privacy and confidentiality of all records pertaining to your treatment, except as otherwise provided by law or third party contact. You may approve or not approve the release of medical information.
- You have the right to ask questions and to an understandable explanation of the diagnostic or treatment component.
- You have the right to be fully informed of what services are available, as well as the fees for all services.
- You have the right to participate in decisions regarding your treatment and to be fully informed of the benefits and risks associated with any treatment component.
- You have the right to refuse any diagnostic procedures and treatment and to the extent permitted by law and to be informed of the risks associated with refusing to be treated.
- You have the right to express complaints and concerns at any time.
- You have the right to change your medical provider at any time.
- You have the right to express those spiritual beliefs or cultural practices that do not harm others or interfere with medical procedures.
- You have the right to seek assistance (interpreter, wheelchair, etc.) during your visit. (Please make any special arrangements when scheduling your sleep study).

Patient Responsibilities:

- You have the responsibility to keep your appointments, be on time, and when unable to do so, provide 48 hour notice to reschedule or cancel.
- You have the responsibility of being considerate of other patients and staff.
- You have the responsibility of respecting the property of others.
- You have the responsibility of letting your medical care provider know when you do not understand what is being told to you with regards to your treatment or illness.
- You have the responsibility of reporting any changes in your address, telephone number and financial status.
- You have the responsibility of obtaining previous medical records when requested.
- You have the responsibility of providing accurate information on the medical history questionnaire.
- You have the responsibility of doing what you and your healthcare provider have agreed upon with regards to treatment. You must understand that if you do not do so, then you will be responsible for the outcome.
- You have the responsibility to be honest with personnel.

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A Night in the Sleep Lab

The architecture of sleep - that is, the distribution of sleep stages - is revealed through sleep studies. Excessive sleepiness, insomnia, disturbing physical events (such as breathing and muscle problems), and even depression, can be diagnosed with such testing.

You are not alone with your problems. Millions of Americans – in fact, more than 100 million – are poor sleepers. The good news is that sleep disorders can be diagnosed accurately and managed effectively. If you have been scheduled to spend a night, or a series of nights, in a sleep lab, relax! Results obtained from patients around the country have shown that a positive difference in sleep can be achieved in approximately 80% of patients following sleep lab studies and appropriate treatment by sleep specialists. Most likely, you will be scheduled to undergo a Polysomnogram, a complex test that evaluates the quality and quantity of sleep stages. Continuous recordings of brain waves, heart and lung function, eye movement, leg movement, chin, chest and actual airflow changes are made. EKG and oxygen levels are also recorded.

The sleep lab environment is safe and conducive to sleep. It is dark, quiet, and pleasing, with a controlled, comfortable temperature.

HOW TO PREPARE FOR THE SLEEP LAB

Most importantly, maintain your normal daily schedule, and avoid starting a new diet or exercise program until after the sleep study. Be sure to tell the sleep center personnel about any medications you are taking. Generally, patients do not need to discontinue other medications, but the sleep lab personnel should know about them, nevertheless. Prior to arriving, shampoo your hair and do not apply oils or conditioners, as they may interfere with establishing good electrode contacts. Remove acrylic fingernails and any fingernail polish from your right index finger. If you are to report for a sleep study at 9:00 PM, eat your evening meal at least 1 to 1.5 hours before arriving. Avoid caffeine containing foods, including coffee, tea, cola, and chocolate during each day of the scheduled study. Also, avoid alcoholic beverages. And do not take naps during the day. Bring your regular, comfortable nightclothes (no gowns please), a robe and slippers.

HOW IS THE POLYSOMNOGRAM PERFORMED?

A specially trained technician will conduct the evaluation. After you are dressed for sleep, the technician will apply approximately 20 small, lightweight electrodes – with a thick paste – to your scalp and skin. You may feel a slight tingling sensation where the skin is cleaned, but that's all. Once you are in bed, the technician will apply an oxygen sensor to your finger and straps around your chest and stomach to help measure your breathing and how your sleep is being disrupted. The wires attached to the monitors are plugged into a box and then into a cable making it easy to disconnect, should you need to get out of the bed during the night to use the bathroom. All that is required is to disconnect the cable. The technician will be in an adjacent room monitoring your sleep. You will be observed by both camera and intercom should you need anything.

HOW LONG WILL THE MONITORING LAST?

An overnight sleep study usually ends around 5:00AM to 6:00AM the following morning. If a "nap study" or Multiple Sleep Latency Test is requested, it follows the overnight study and ends around 4:30 PM.

WHEN ARE THE RESULTS KNOWN?

A tremendous volume of sleep information is collected on paper and in the computer. A lab technician scores all of the data. Then, the sleep study, your sleep history, physical examination, observation notes from the technicians, and any other testing you may have had performed will be forwarded to the Sleep Specialist. Careful interpretation of all results is then undertaken, and this leads to a diagnosis of the sleep problem, as well as recommendations for treatment. The final report should be completed in three to five days. You will probably have a follow-up visit with your referring physician and/or the Sleep Specialist to discuss the results and appropriate treatment options. If you have any questions, do not hesitate to ask. The sleep lab personnel are ready to help you understand and make you comfortable during your stay in the sleep lab.

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Frequently Asked Questions

During a sleep center evaluation, what time will I get up?

A typical sleep study concludes between 5:00AM and 6:00AM.

How do I go to the Bathroom?

Bathrooms are conveniently located near the testing rooms. The technician is there to assist you if necessary.

When do I take my nightly medication?

You should bring all medications you usually take at night with you and take as ordered by your physician.

When do I get my results?

Results are sent to the referring physician within 5 -7 days.

Can a family member stay with me?

This is a medical procedure and therefore it will be necessary for you to sleep alone. A family member may accompany the patient in the event that the patient is a minor or if the patient has special needs. It is recommended that this is noted at the time the study is scheduled, so that proper arrangements can be made for their comfort.

Will I have to sleep on my back?

It will be necessary to be in the supine position during some of the testing. It is not a requirement for the entire study.

Does insurance pay for my studies?

Sleep studies are covered by most insurance companies including Medicare. We contact your insurance company prior to testing to verify benefits. If you have specific questions on billing, please contact PCCA. You should also contact your insurance company using the customer service number on the back of the card for additional information.

What is a NPSG?

Nocturnal Polysomnography- or sleep study. This test is considered the "Gold Standard" in diagnosis of sleeping disorders. The NPSGT measures EEG (Brain Waves) EOG (eye movement) EMG (Muscle Movement), Respiratory Airflow, Respiratory Effort, Oxygen Saturation, Snoring, EKG (Heart Activity), Arm and Leg Movement and body position. This information is collected for 6-8 hours and is analyzed to note any patterns or behaviors that are impacting sleep.

What is a MSLT?

Multiple Sleep Latency Test. This determines how fast you fall asleep in the dark. The test consists of a series of 20 minute naps in 2 hour intervals throughout the day.

What is a CPAP?

Once the NPSGT is reviewed by a qualified physician and Sleep Disordered Breathing or Sleep Apnea is identified, treatment for this condition utilizes a device that supplies Continuous Positive Airway Pressure or CPAP. In order for this to be effective a second sleep study wearing the device is necessary to obtain the optimal settings, masks and effectiveness of the procedure. This test is just like the NPSGT with the addition of the CPAP unit.

If I need to postpone my study, do I need to cancel 24 hours in advance?

You need to cancel and reschedule as soon as it is convenient for you. This is a medical procedure that may have severe medical consequences if not completed timely and properly. If the study must be cancelled, please do so as soon as possible. Since sleep studies are an overnight procedure another patient cannot be put in your place if you fail to cancel in a timely manner. There is a no-show fee assessed for failure to cancel the sleep study.

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SLEEP DISORDER QUESTIONNAIRE

Name:			**SSN**:
Address:			
Street/PO Box		*City*	
Phone: ( )	( )		( )
Home	*Work*		*Other*
DOB: / /	**Age**:	**Sex**: M ☐ F ☐	**Marital Status**: S M D W
Height: ft. in.		**Weight**: lbs.	
Emergency Contact(s):			
Name:	Phone : ( )	Relationship:	
Name:	Phone : ( )	Relationship:	
Employer/Occupation:			

Insurance Information	
Medicare #:	**Medicaid #:**
Primary Insurance:	**Secondary Insurance:**
Insured's Name:	Insured's Name:
Insured's SSN:	Insured's SSN:
Insured's DOB:	Insured's DOB:
Relationship to Insured:	Relationship to Insured:
Insurance Company:	Insurance Company:
Address:	Address:
Phone:	Phone:
Policy #: Group#:	Policy #: Group#:

I authorize release of any medical or other information necessary to process insurance claims/related treatment to the health care financing administration and its agents. I am responsible for payment of services rendered.

Signature: _____ Date: _____

The sleep studies and follow up treatments are covered by most major insurances and by Medicare. Should your specific policy not cover sleep studies, you WILL be notified <u>PRIOR</u> to your study.

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SLEEP DISORDER QUESTIONNAIRE

The Epworth Sleepiness Scale

Name: _____

How likely are you to doze off or fall asleep in the situations described in the box below, in contrast to feeling just tired? This refers to your usual way of life in recent times. 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

Situation	**Score**
Sitting and reading…….	[ ]
Watching TV…….	[ ]
Sitting inactive in a public place (e.g. a theatre or meeting)…….	[ ]
As a passenger in a car for an hour without a break…….	[ ]
Lying down to rest in the afternoon when circumstances permit……..	[ ]
Sitting and talking to someone……..	[ ]
Sitting quietly after a lunch without alcohol…….	[ ]
In a car, while stopped for a few minutes……..	[ ]
Total	

The score is simply the addition of all eight answers. Less than 10 is considered normal.

1. Are you bothered by sleepiness under other circumstances? Yes ☐ No ☐
   If yes, describe: _____
2. Have you been in a car accident due to falling asleep at the wheel? Yes ☐ No ☐
3. Have you had a near miss due to falling asleep at the wheel? Yes ☐ No ☐
   If yes, describe: _____
4. Have you had other types of accidents because of sleepiness: Yes ☐ No ☐
   If yes, describe: _____

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SLEEP DISORDER QUESTIONNAIRE

Sleep History

Name: _____

5. Do you take naps? Yes ☐ No ☐ If so, how often?_____Are they refreshing? Yes ☐ No☐
6. What time do you usually go to bed?_____AM ☐ PM ☐
7. What time do you usually wake up in the morning?_____AM ☐ PM ☐
8. How many hours of actual sleep do you think you get each night on average? _____
9. Does your routine change on the weekends?_____How long does it take for you to fall asleep?_____
10. How many times do you wake at night?_____How long does it take to fall back asleep? _____
11. Upon wakening in the morning, do you feel: Completely rested ☐ Partially rested ☐ Not rested at all ☐
12. Over the past few months/years has this improved or worsened?_____
13. Can you explain why?_____
14. **Have you previously had a sleep study?** Yes ☐ No ☐

If so, please fill out as much of the following information as you can.

Initial Study Date:_____/____/_____ Location:_____

Physician:_____

CPAP/BiPAP Study Date:_____/____/_____Location:_____

Physician:_____

Post ENT Study Date:_____/____/_____ Location:_____

Physician:_____

If you use the following equipment please complete the blanks:

CPAP Pressure:_____Cm/H20 Oxygen:_____ LPM

BiPAP Pressure:_____Cm/H20

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SLEEP DISORDER QUESTIONNAIRE

Medical History

Name: _____

Family History- ***Please check all that apply***

	Mother	Father	Siblings
Heart Disease			
Stroke			
High Blood Pressure			
Diabetes			
Cancer			
Sleep Apnea			
Thyroid Disease			
Narcolepsy			
Insomnia			

Previous Medical History - ***Circle those that apply***

ENT	Heart	Lung	GI	Endocrine	Neurological	Misc
Sinusitis	Hypertension	Asthma	Reflux Disease	Thyroid Disease	Stroke	Chronic Pain
Nasal Polyps	CAD	Chronic Bronchitis	Esophagitis	Diabetes	Head Injury	Degenerative Joint Disease
Deviated Septum	Heart Attack	COPD	Hiatal Hernia	Menopause	Seizures	Fibromyalgia
	Congestive Heart Failure	Emphysema			Anxiety	Chronic Fatigue
	Arrhythmias	Pulmonary Fibrosis			Neuropathy	Muscle Weakness
	Blood Clots	Pulmonary Hypertension				Arthritis
	Pacemaker	Recurrent Pneumonia				

Review of Symptoms - ***Circle those that apply***

Sinus infection	Dizziness	Shortness of breath	Frequent nausea	Increased Thirst	Memory loss	Weight gain
Ear infection	Palpitations	Difficulty swallowing	Vomiting	Lymph node enlargement	Depression	Anemia
Post nasal drip	Chest pain	Cough	Blood in stool	Frequent urination	Visual loss	Night sweats

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SLEEP DISORDER QUESTIONNAIRE

Surgical History and Social History

Name: _____

15. **Have you had any nasal surgeries? Yes ☐ No ☐ if yes, please explain** _____

16. **Have you had any throat surgeries? Yes ☐ No ☐ if yes, please explain** _____

_____

17. **Have you had any other surgeries? Yes ☐ No ☐ if yes, please explain** _____

_____

18. If employed, what are your working hours? Start:_____AM/PM Stop:_____AM/PM

19. How long have you been on this work schedule? _____

20. Are you currently pregnant? **Yes ☐ No ☐**

21. Are you currently taking oral contraceptives? **Yes ☐ No ☐**

22. What is the average number of drinks you have per day of alcoholic beverages: _____

23. What is the average number of drinks you have per day of caffeinated beverages such as coffee, tea or soda: ____

24. Do you smoke? Yes ☐ No ☐ For how long?_____Number per day? _____

25. Please list your primary care physician or practice

_____

26. Please list any other physicians and specialists you see

_____

_____

_____

_____

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SLEEP DISORDER QUESTIONNAIRE

Medications

Are you allergic to any medication? Yes ☐ No ☐ Medication name(s): _____

List all medications (prescribed or otherwise) that you are currently using or have used within the last 30 days. Also list any medication you have used in the past to help your sleep problem: (*add additional sheet if necessary)*

Medication:		Amount:		Last Taken:	
Medication:		Amount:		Last Taken:	
Medication:		Amount:		Last Taken:	
Medication:		Amount:		Last Taken:	
Medication:		Amount:		Last Taken:	
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PATIENT CHECKLIST QUESTIONNAIRE

Please check all statements that apply.

_____ I have been told that I snore.
_____ I often feel sad or depressed.
_____ I have been told that I hold my breath while sleeping.
_____ I have trouble concentrating at work or school.
_____ I have high blood pressure.
_____ I have fallen asleep while driving.
_____ I have been told by friends and family that I am often grumpy or irritable.
_____ I have experienced vivid dreamlike scenes upon falling asleep or awakening.
_____ I sweat excessively during the night.
_____ I have fallen asleep in social settings such as the movies or parties.
_____ I have noticed my heart pounding or beating irregularly during the night.
_____ I have dreams soon after falling asleep or during naps.
_____ I get morning headaches.
_____ I have “sleep attacks” during the day no matter how hard I try to stay awake.
_____ I suddenly wake up gasping for breath.
_____ I have had episodes of feeling paralyzed during my sleep.
_____ I am overweight.
_____ I wake up at night with an acid/sour taste in my stomach.
_____ I seem to be losing my sex drive.
_____ I wake up at night coughing or wheezing.
_____ I often feel sleepy and struggle to remain alert.
_____ I wake up suddenly during the night feeling like I am choking.
_____ I frequently wake with a dry mouth or sore throat.
_____ I experience muscle tension in my legs at times other than when exercising.
_____ I have difficulty falling asleep.
_____ I have noticed (or others have commented) that parts of my body jerk during sleep.
_____ I have thoughts racing through my mind preventing me from sleeping.
_____ I have been told that I kick at night.
_____ I wake up and cannot go back to sleep.
_____ I experience an aching or crawling sensation in my legs while trying to go to sleep.
_____ I worry about things and have trouble relaxing.
_____ I experience leg pain or cramps at night.
_____ I wake up earlier in the morning than I would like.
_____ I occasionally cannot keep my legs still at night; I have to move them to feel comfortable.
_____ I lie awake for half an hour or more before falling asleep.
_____ I feel sleepy during the day even though I slept through the night.
_____ I have a history of coronary artery disease, heart attack, cardiac surgery or congestive heart failure.
_____ I am already on CPAP/BIPAP and pressure setting.
_____ I am on oxygen.
_____ I have had surgeries for sleeping or sleep apnea.
_____ I have asthma.