Northern Arizona Healthcare

NAHMG Cardiology-Sleep Flagstaff
2000 S. Thompson St.
Flagstaff, AZ 86001
P: (928) 226-6400
F: (928) 226-6411

NAHMG Sleep Cottonwood
1759 E. Villa Drive, Ste. 313
Cottonwood, AZ 86326
P: (928) 639-5095
F: (928) 639-6049

Sleep Study Information

Your sleep study appointment is scheduled for _____

Your follow-up consultation is scheduled for _____

Your COVID-19 test must be completed between _____ (4-7 days prior to the sleep study).

We are looking forward to having you as our guest in our sleep center. **Please read and complete the attached/included Sleep History Questionnaire**.

Flagstaff Address: 2000 S. Thompson St. Flagstaff, AZ 86001
928-226-6406 Night time number only
****The sleep lab entrance is located off Thompson St. on the other end of the building from the main clinic entrance.****
Cottonwood Address: 1759 E. Villa Drive Ste. 313 Cottonwood, AZ 86326
P: (928) 639-5095

Before your appointment

Please let us know if you have any special needs, particularly special medications, pulmonary treatments, supplemental oxygen, and difficulty walking or getting in and out of bed and or using the restroom. If you are not self-sufficient and/or require a caretaker or family member for assistance please inform the lab ASAP so proper arrangements can be made.

Polysomnogram (PSG) – Overnight Sleep Study

A PSG is a recording during sleep that uses EEG (brain activity), breathing and other physiologic measures to evaluate sleep disorders. Patients usually come to the laboratory in the evening and stay overnight for continuous monitoring. The study is usually complete around 5:00 to 6:00 am.

The technologist records various information for interpretation by our sleep medicine physician. Sleep studies are utilized to help evaluate patients who experience excessive sleepiness during the day, snoring, high blood pressure as well as other heart and medical conditions. There are many sleep disorders and the most common is sleep apnea, which is repeated interruptions in breathing while asleep.

How to prepare for your sleep study

- **Please complete the included/attached Sleep History Questionnaire and bring with you to your appointment.**

- Please have your hair and skin clean and free of all hairsprays, lotions, and oils. ***One fingernail needs to be free from acrylics and/or nail polish.***
- Try to follow your normal routine – no excessive exercise, stress, eating, etc.
- Avoid caffeine and alcohol after 12 pm on the day of your study.
- Take your regular medication as directed by your physician and **bring all medications that you may need during your stay at the lab.**

What to Bring

- Comfortable, loose fitting clothing for sleep.
- Your normal nighttime medications.
- Also, feel free to bring a book, magazine, laptop/tablet or other items that will help you feel comfortable while staying away from home.
- Please **do not** bring pillows, blankets, or an overnight bag.

What to expect when you arrive at the lab

- First, you will be screened for COVID-19 symptoms and your temperature will be taken. You will be required to wear a mask per COVID-19 precautions until the sleep study begins.
- Then, the sleep technologist will show you to your bedroom. You will be able to finish any questionnaires and change into your nightclothes.
- The sleep technologist will explain your procedure in great detail and answer all your questions before they begin.
- The sleep technologist will then apply electrodes to you scalp to record brain waves and elastic belts to monitor your breathing. Other electrodes are used to monitor eye movements, heart rhythms, and leg movements. You will be sleeping alone in the recording room, but monitored by the technologist via closed circuit video.

Following your sleep study

- You will be finished between 5:00 and 6:00am in which time you will complete morning questionnaires.
- Patient showers at the lab are not permitted due to the COVID-19 pandemic.
- A sleep center staff physician will review you sleep study and make recommendations for treatment based upon the results of your study.
- **If you have not made a follow-up appointment with our Sleep provider team, please call us at 928-226-6400 to schedule.**

Frequently Asked Questions

Will I have my own room?

Yes, you will have a private bedroom with a television and premium cable channels.

What if I need to use the restroom?

No problem. The wires are all arranged for easy access to the restroom. You will simply call out to your technologist who will promptly respond and disconnect you from the wall connections for you to be able to use the restroom at any point during the night.

If you need assistance getting in/out of bed or while using the restroom, please notify us prior to your study and ASAP as special staffing and scheduling arrangements will need to be made.

What if I need to wake early for work or personal reasons?

If you need to wake early for any reason, please notify your technologist before your test begins. We need to record at least 6 hours for a complete sleep study.

What should I bring?

We want your stay with us to be as comfortable as a night in your own bedroom. Bring comfortable, loose fitting clothing to sleep in and your normal nighttime medications. You are also welcome to bring a book, magazine, laptop/tablet or other items that will help you feel comfortable while staying away from home. **Please do not bring pillows, blankets, or an overnight bag.**

In addition, please remember to bring your completed Sleep History Questionnaire.

Do I take my medications?

Take all of your regular medications on the day of your study unless otherwise specified by your physician. Please remember to bring any medications that you usually take before bedtime or when you wake up in the morning. We are an outpatient facility and do not have access to medications.

Can I bring a drink or snack?

Please eat dinner before you arrive for your sleep study. However, you may bring your own snacks to keep in the bedroom with you.

How does a sleep study work?

Once it is time to begin the study, you will be hooked up to approximately 20 small wires, which are held in place with tape and other adhesives. This takes approximately 30 minutes. All of these sensors help us measure your brain activity, heart rate/rhythm, breathing patterns, snoring, oxygen levels, and leg movements. This is a non-invasive procedure and no needles are used in this process. The sensors are attached using all hypoallergenic medical tape and water-soluble paste.

Will I be able to sleep with all those wires on me?

Most patients say that once all the wires are on, they forget about them and have very little trouble sleeping. The wires are very small and organized. You have full range of motion in your bed and are able to sleep in all positions.

Do I have to sleep on my back?

You are able to sleep in any position that is comfortable for you. It is helpful for the physician to make an accurate diagnosis to see how your body responds to sleeping in several positions (on your side and on your back) so you may be asked to try to change positions at some point during the night.

Do I have to go to bed that early?

We want to simulate your normal bedtime routine as much as possible. Upon your arrival to the sleep lab, there is time for you to complete the check-in process, relax, and get set up for the sleep study. Most sleep studies begin with lights off between 9:00 and 11:00pm.

Can my spouse/friend/family come?

Your friends and family members are asked to remain home as we are limiting visitors at our facility during the COVID-19 pandemic to keep patients and staff safe.

What are you doing to keep patients safe during the COVID-19 pandemic?

All patients are required to have a negative COVID-19 test within 7 days of the sleep study. A COVID-19 symptoms screening is also completed at time of scheduling and upon arrival to the sleep lab for all patients as well as staff. At the sleep lab, we are limiting patients to half our normal capacity and no visitors, family, or friends are permitted in the sleep lab unless approved for medical reasons.

CPAP/BIPAP studies are performed using non-vented full-face masks and air scrubbers, which limit the staff and patient exposure to the potential airborne spread of the virus.

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SLEEP MEDICINE HISTORY FORM

NAME _____DOB _____ DATE _____

Sex: M / F Weight:_____lbs Height:_____ft _____in

Primary Care Provider:_____ Collar size (inches): _____

SLEEP ROUTINE:

What TIME do you GO TO BED? _____

1. How long does it take for you to fall asleep? _____
   What occurs during that time?_____
2. Do you frequently wake up in the middle of the night? YES/NO
   a. If YES, how many times? _____
   b. What is the reason for waking up during the night? _____
   c. How long does it take you to return to sleep? _____
3. What TIME do you WAKE UP in the morning? _____
4. Do you feel REFRESHED UPON WAKING UP? YES/NO
5. Do you take any
   a. Scheduled/Planned Naps YES/NO When_____How Long_____
   b. Unscheduled/Unplanned Naps? YES/NO ___When driving

      ___ When inactive

      ___ In conversations

   c. IF YES, Do you feel refreshed after the nap? YES/NO
6. Any change in sleep schedule on your DAYS OFF? _____
7. Have you recently had any change in your WEIGHT in the PAST 3 YEARS? GAINED/LOST How much? _____

SLEEP APNEA SYMPTOMS:

8. Has anyone told you that you SNORE? YES/NO
   a. If YES, How LOUD? MILD/ MODERATE/ LOUD/ VERY LOUD

   Has anyone seen you STOP BREATHING or have pauses in breathing when you sleep? YES/NO

9. Do you wake-up from sleep with a CHOKING/GAGGING sensation? YES/NO
10. Has anyone told you that you

    MAKE SNORTING/GASPING noises in sleep? YES/NO

11. Do you wake up with a DRY MOUTH? YES/NO
12. Do you wake up with a HEADACHE? YES/NO
13. Do you DROOL on the pillow? YES/NO
14. Do you feel TIRED during the day? NO/ Mild/ Moderate/ Severe

RESTLESS LEGS:

15. Do you have UNCOMFORTABLE SENSATIONS in your legs before bedtime? YES/NO
16. If YES, please describe them? _____
17. Do you have any of the following during sleep?
    a. SLEEPWALKING YES/NO
    b. SLEEP TALKING YES/NO
    c. NIGHTMARES YES/NO
    d. ACTING OUT DREAMS YES/NO

SLEEP HYGIENE:

1. Do you do any of these activities in your bed/bedroom?
    a. WATCH TV YES/NO
    b. EAT YES/NO
    c. READ YES/NO
2. Do you drink coffee/caffeinated beverages? Never/Occasional/Moderate
3. SMOKING Never/Former/Current
4. Do you drink ALCOHOL? Never/Occasional/Moderate
5. Do you use illicit drugs? YES/NO Type_____

MISCELLANEOUS:

1. When FALLING ASLEEP or WAKING UP
    a. Do you ever SEE or HEAR things? YES/NO
       If YES, DESCRIBE _____
    b. Do you ever FEEL PARALYZED? YES/NO
2. Do you ever feel SUDDEN MUSCLE WEAKNESS when you are laughing? YES/NO

DRUG ALLERGIES: Check box if no known allergies to any medications ❑.

a. Drug name_____- What Reaction?_____
b. Drug name_____- What Reaction?_____
c. Drug name_____- What Reaction?_____

FAMILY HISTORY:

1. Does anyone in your family have sleep apnea? YES/NO
    a. If YES, who? _____

CURRENT MEDICATIONS: Please list all of your current medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever had a SLEEP STUDY before? NO/YES where?_____

PAST MEDICAL HISTORY

❑ Hypertension (high blood pressure)	❑ Nasal allergies / nasal congestion	❑ Thyroid disease
❑ Heart attack	❑ Congestive heart failure	❑ Diabetes
❑ Cardiac arrhythmias	❑ Stroke / TIA	❑ Heartburn / reflux
❑ Atrial fibrilation	❑ Pulmonary hypertension	❑ Fibromyalgia
❑ Lung problems / COPD / Asthma	❑ Anemia / iron deficiency	❑ Menopause
❑ Parkinson's disease	❑ Seizures	❑ Cancer
❑ Arthritis	❑ Autoimmune disease	❑ Broken nose
❑ Depression / anxiety / bipolar	❑ End stage kidney disease / dialysis	❑ Head injury
❑ Pacemaker	❑ Chronic Pain (reason)_____	

❑ Other: _____

SURGERIES:

Please list all your surgeries

_____

_____

_____

REVIEW OF SYSTEMS:

Check the symptoms you frequently experience:

Const: ❑ Fever ❑ Feeling poorly ❑ Feeling tired ❑ Chills

ENT: ❑ Ear pain ❑ Frequent nosebleeds ❑ Sore throat ❑ Hearing loss o Nasal discharge ❑ Hoarseness lasting more than 2 weeks ❑ Nasal congestion

Heart: ❑ Passing out ❑ Chest pain, tightness or pressure ❑ irregular heartbeat ❑ Palpitations ❑ Swelling of feet/ ankles

Resp: ❑ Shortness of breath ❑ Frequent cough for more than 2 weeks ❑ Wheezing

GI: ❑ Abdominal pain ❑ Difficulty swallowing/ food "sticking" ❑ Frequent heartburn/ indigestion ❑ Constipation ❑ Diarrhea ❑ Nausea ❑ Vomiting

MSK: ❑ Joint pain ❑ Joint swelling ❑ Joint stiffness ❑ Limb pain ❑ Limb swelling ❑ Muscle pain ❑ Back pain

Neuro: ❑ Frequent headaches ❑ Seizures ❑ Numbness/tingling ❑ Weakness ❑ Ringing in ear(s)

Behav: ❑ Anxiety ❑ Change in personality ❑ Sleep disturbance ❑ Depression

Hema: ❑ Swollen glands ❑ Easy bleeding ❑ Easy bruising

GU: ❑ Nocturia ❑ Incontinence ❑ Sexual dysfunction/loss of libido

NORTHERN ARIZONA HEALTHCARE

EPWORTH SLEEPINESS SCALE FORM

NAME _____ DOB _____ DATE _____

The test is a list of eight situations in which you rate your tendency to become Sleepy

Instructions: Be as truthful as possible.

Write down the number corresponding to your choice in the right hand column. Total your score below.

No chance of dozing =0

Slight chance of dozing =1

Moderate chance of dozing =2

High chance of dozing =3

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater or a 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 in traffic	

Total Score = _____