SLEEP SCREENING

Patient Information

First Name: MI:

Last Name:

Height: Weight:

Gender: F or M Age:

BMI (Calculated): Neck Size:

STOP BANG Screener (Check Yes or No)

	YES	NO
S (snore) Do You Snore?	☐	☐
T (tired) Do you feel fatigued during the day?	☐	☐
Do you wake up feeling like you haven't slept?	☐	☐
O (obstruction) Have you been told you stop breathing at night?	☐	☐
Do you gasp for air or choke while sleeping?	☐	☐
P (pressure) Do you have high blood pressure?	☐	☐
Are you on medication to control high blood pressure?	☐	☐

Score: If you checked YES to 2 or more questions on the STOP portion you are at risk for OSA.

Check YES or NO

	YES	NO
B (BMI) Is your body mass index greater than 28?	☐	☐
A (age) Are you 50 years old or older?	☐	☐
N (neck) Are you a male with a neck circumference greater than 17 inches, or a female with circumference greater than 16 inches?	☐	☐
G (gender): Are you a Male?	☐	☐

Score: The more questions you checked YES on the BANG portion, the greater you're at risk of having moderate to severe OSA.

Epworth Sleepiness Scale- Rate 0-3

How likely are you to doze off or fall asleep in the situation described below, in contrast to feeling just tires? This refers to your usual way of life in recent times. Even if you haven't done some 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

Please fill in the box with the scale number.

Situation	Score
Sitting Reading	☐
Watching TV	☐
Sitting inactive in a public place (E.g. a theatre or a meeting)	☐
Sitting in a car as a passenger for a continuous hour	☐
Lying down to rest in the afternoon when circumstances permit	☐
Sitting and talking to someone	☐
Sitting quietly after a lunch without alcohol	☐
Sitting in a stopped car in traffic for a few minutes	☐
Total:	☐

The higher your scale, the greater the chance that you are at risk for OSA.

Inell C. Rosario, MD
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Board Certified in Sleep Medicine

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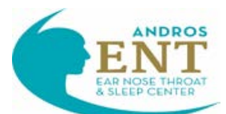
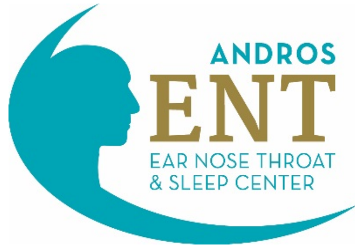
Clinic: 651-888-7800



1. Have you ever had a sleep study? YES NO
   If yes, when and where? ________________________
2. Have you ever been diagnosed with a sleep problem? YES NO
   If yes, which one? ______________________________
3. Do you snore? YES NO (If no, go to question #7)
4. How long have you snored? ______________________
5. In which positions do you snore?
   BACK ONLY ALL POSITIONS (circle one)
6. Do you snore if you fall asleep in a chair? YES NO
7. Do you have a dry mouth in the morning? YES NO
8. Do you have headaches in the morning? YES NO
9. Do you dream while asleep at night? YES NO
10. Do you feel sleepy during the day YES NO (if no, go to question #12)
11. Is your daytime sleepiness worsening? YES NO
12. Do you take daytime naps? YES NO (if no, go to question #17)
13. How many naps do you take per week? ____________
14. How long do your naps last? ______________________
15. Do you dream during naps? YES NO
16. Are the naps refreshing? YES NO
17. Have you ever had a close call or accident while driving because of sleepiness? YES NO
18. Do you suffer from memory problems? YES NO
19. Are you more irritable lately? YES NO
20. Have you ever had sudden loss of strength in arms or legs when laughing or scared? YES NO
21. Have you ever felt paralyzed when you first wake up, or when you fall asleep? YES NO
22. Do you sleep walk? YES NO
23. Do you sleep talk? YES NO
24. Do you ever have urinary accidents in bed? YES NO
25. Do you have nightmares? YES NO
26. What time do you go to bed? _____________________
27. What time do you wake up? ______________________
28. What are your working hours?___________________ YES NO N/A (go to #30)
29. Is this a regular or rotating schedule? (circle one)
30. How long does it take to fall asleep? _______________
31. Do you wake up in the middle of the night? YES NO (if yes go to #32)
32. How many times? _______________________________
33. Do you fall asleep easily? YES NO
34. How many cups of caffeine do you have a day ____Coffee ____Tea ____Soda
35. Do you use over the counter or prescription sleep medications? YES NO (if yes, please list)



Andros ENT & Sleep Center
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Sleep Study or Polysomnogram (PSG) Procedure:
When you arrive at the center your technologist will ask you to change into your nightclothes and fill out a bedtime questionnaire. She/he will then mark and measure your head to a apply electrodes to your scalp to monitor your brainwaves (EEG). Don't worry the electrodes are generally not noticeable and all monitoring devices are applied to the surface of your skin. We will use a skin scrub to exfoliate the areas where the electrodes are placed. Please note that there will be 2 patients and 1 sleep tech the night of your sleep study.

The entire set up procedure takes approximately 45 minutes. Once all of the electrodes are applied everything is plugged into a "head-box", all of the leads are neatly bundled into a "pony-tail" and you will be able to move freely around the Sleep Center. Your technologist will explain everything to you throughout the set-up process.

We will be monitoring the following parameters:

EEG: Electroencephalograph or brainwaves, to monitor your stages of sleep.
EOG: Electroculograph or eye movements to monitor when you reach REM sleep or dream sleep.
EMG: Electro-myograph or muscle activity to monitor limb movements and chin activity.
EKG: Electro-cardiograph to monitor your heart beat and rhythm.
Oximetry: To monitor the amount of oxygen in your blood, the device will be applied to your index finger.
Effort: Monitors your effort to breathe while sleeping

After the set-up procedure is complete your technologist will acclimate you to CPAP or **C**ontinuous **P**ositive **A**irway **P**ressure. **CPAP** is the primary treatment for sleep apnea. This device gently blows air into your nose and or mouth through a small mask. The CPAP helps to keep the airway open so that you can breathe normally throughout the night.

Items to bring with you for your stay at Andros ENT and Sleep Center

- Sleeping attire, comfortable and loose fitting.
- Personal pillows or blankets.
- Toiletry items: tooth brush, tooth paste, shaving kit, make-up bag. Please note if you are a man with facial hair you might be asked to shave prior to the sleep study.
- Reading material such as a book, in case you don't find something to watch on television.
- Medications: Please bring your evening and morning medications with you. If you normally take a sleep aid, feel free to bring it along with you to the sleep study. If you decide to take it please let your technologist know the time and dose of the medication. If Dr. Rosario or Dr. Dahm prescribes a sleep aid for your sleep study, please have your prescription filled, and bring the sleep aid with you. You might also want to bring anything that you normally take for headache/or pain. Just in case you develop a headache or body aches while you are here. **The Sleep Center is staffed by technologists not nurses, we do not stock medications, and we cannot administer any medications.**
- If you bring your cell phone with you please ensure that it is **turned off/or in the do not disturb mode** during your sleep testing.

During the Night:

We typically start the sleep study between 10:00 and 11:00 p.m. You will go to sleep as you normally would at home. Prior to lights out the technologist will ask you to perform a series of simple tasks such as looking up/down and left/right, holding your breath and flexing your feet. This is to ensure that all of the signals are clear and that the equipment is working.

You are allowed to sleep in any position during the night, at some point during the night we would like you to sleep on your back. We are most likely to see snoring or apnea in that position. If you have a medical condition that prevents you from sleeping on your back please inform your technologist. You are allowed to get up and use the restroom as needed.

During the baseline portion of the sleep study the technologist is counting any events that occur, including snoring, breathing events, leg movements, arousals, heart arrhythmias and body position.

If needed your technologist will apply **CPAP** to treat your sleep apnea. They will be monitoring your response to **C**ontinuous **P**ositive **A**irway **P**ressure. This device gently blows air into your nose through a small mask. **CPAP** helps keep the airway open so that you can breathe normally throughout the night.

Everyone requires a different **CPAP** pressure and your technologist will be adjusting the pressure via a remote control throughout the night. During a CPAP titration you are allowed to sleep in any position however we will request that you sleep on your back at when you are wearing the CPAP during your sleep study. The reason we ask this is because snoring and apnea occur more frequently when you are sleeping on your back.

If you already use PAP or other therapy such as a dental device for your sleep apnea, please bring this with you. Your technologist will verify the pressure and mask fit.

In the Morning:
Please let the sleep tech know if you need to leave by a certain time and they will give you a wakeup call. After your sleep study the technologist will remove all of the monitoring devices. This process takes about 15 to 20 minutes. You will work with the sleep tech to find what time you need to leave by, to accommodate your normal daily routine. Afterwards you are free to shower here or at home. We will also provide you with coffee and small breakfast items.

If you are scheduled for a Multiple Sleep Latency Test (MSLT):
You may be required to stay for a **M**ultiple **S**leep **L**atency **T**est **(MSLT).** This test occurs immediately following your sleep study. You will spend the day in the lab to perform a series of "Nap Studies". Most of the monitoring devices used at night will be removed and you are requested to change into your street clothing. Please note, that including your sleep study, you may be here up to 24 hours so ensure that you have all the medications you require. We do provide a light breakfast but request that you bring in something for lunch. We do have a refrigerator and microwave for your use. We also ask that you keep your caffeine intake to a minimum.

The first nap starts 90 minutes to 2 hours after you wake up for the day. Additional naps will take place about every 2 hours, for a total of 4-5 naps. Each nap study lasts about 20-30 minutes, and between naps you are free to read, watch TV, and catch up on work. We do have WiFi. For each nap study, we look objectively at if you sleep, how it takes you to fall asleep, and what stages of sleep you have.

If you are scheduled for a Maintenance of Wakefulness Test (MWT):
If you are scheduled for a **M**aintenance of **W**akefulness **T**est (**MWT**) you may need a sleep study immediately before the MWT. This will be ordered by your physician. This is a series of tests similar to an MSLT, but there are a series of 40 minute tests about 2 hours apart. During the tests, you will sit

comfortably in a darkened room. You will need to sit quietly with no attempt to force yourself to stay awake such as moving, singing, etc.

We do provide a light breakfast but request that you bring in something for lunch. We do have a refrigerator and microwave for your use. We also ask that you keep your caffeine intake to a minimum.

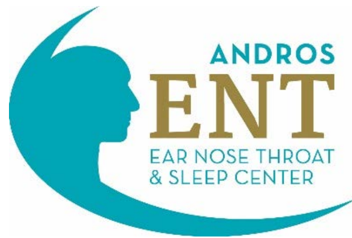
The day of your sleep study:

- Please do not take a nap as this may affect your ability to fall asleep for your test
- Please have freshly washed and dry hair with gel, spray, or any other products in it
- If you have a toupee or weave, it will need to be removed for the study
- Do not wear makeup or jewelry – leave all valuables at home
- If you have acrylic nails or nail polish, you may need to remove it from one nail prior to your study

What happens when the sleep testing is over?

Once all of the sleep testing is completed and the technologist has collected all of the data, you are free to go home. You may want to shower before you leave and all of the supplies you will need for that will be available in your bathroom.

Please don't ask the technologist to tell you the results of your study. The information and report have to be reviewed by the physician for interpretation. After the physician has done this, the information will be discussed with you at your follow-up appointment. Before you leave please check your room and bathroom for any items you might have left behind, especially pillows and chargers.



Cancellation Policy

Because of the level of service we provide our patients, your appointment is especially held just for you.

Our Cancellation Policy:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving the care they need. Due to the large block of time (8-12 hours) reserved for your sleep study, last minute cancellations can cause problems and added expenses for our office.

We ask that you make every effort to give us at least a **24-hour notice if you cannot make your scheduled appointment**. We understand that situations arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

If your Sleep Study appointment is not cancelled at least 24 hours in advance you will be charged a $100 fee. This fee will not be covered by your insurance.

Thank you for understanding the value of our cancellation policy and our commitment to each of our patients.

By signing below, I acknowledge that I have read and accept the above cancellation policy.

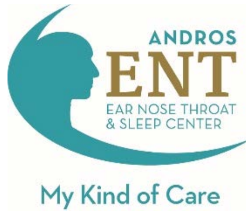
_______________________________	_______________________________
Print Patient Name	Witnessed By
_______________________________	_______________________________
Signature of Patient or Guardian	Date
_______________________________	
Date	

OFFICE USE ONLY

Sleep Study Date:________________

MSLT/MWT Date:________________

Sleep Study follow up:____________



Patient's Phone #:__________________

Sleep Study Pre Auth: _______________

DME Pre-Auth: ____________________

Patient Name: ____________________________________ Date of Birth: ______________________

Primary Provider: _________________________________ Date of Order: ______________________

1. Symptoms (check all that apply):

☐ Snoring/Apnea, concern for Obstructive Sleep Apnea

☐ History of ________________ need re-evaluation

☐ Sleepwalking, sleep terrors, or other parasomnias

☐ Excessive sleepiness or fatigue

☐ Insomnia

☐ Restless Leg Syndrome

EPWORTH SCORE:_______________________

STOP BANG SCORE:______________________________

If patient is currently on PAP therapy:

Pressure? **Mode?**

2. The evaluation begins with a consultation with Andros ENT & Sleep Center; please:

CALL – Andros ENT & Sleep Center at (651)888-7800 to schedule an appointment

and

FAX – this form to (651)888-7801 along with…

a) Patient contact information

b) Pertinent clinical information

Ordering Provider Signature: ___________________________________ **Date:** ____________________

------------------------ *The following section to be completed by Sleep Center Physician* --------------------------

☐ PSG, no MSLT

☐ PSG, MSLT

☐ PSG, MSLT if AHI <5, Epworth >= 10

☐ PSG with CPAP/BIPAP at lights out

☐ 2 consecutive nights PSG/MSLT

☐ PSG, MWT

☐ PSG with baseline then Dental Device Titration

☐ PSG with Dental Device at lights out

☐ Home Sleep Test

☐ Transcutaneous CO_2 monitoring

☐ High definition video

☐ Auditory stimulus in NREM sleep

☐ Four limb EMG

☐ **Zaleplon** (Sonata ®) provided w/Instructions

☐ **Zolpidem** (Ambien ®) provided w/instructions

☐ **Sleep diaries** for ___ weeks **prior** to studies

☐ **Actigraphy** for ___ weeks **prior** to studies

Needs **two hour baseline**

Special needs? ………

☐ 1-to-1 monitoring

☐ Non-ambulatory/risk of falling

☐ Cognitive limitations

☐ Interpreter needed

☐ Early arrival time

☐ Pediatric patient

☐ Other: ____

☐ Comments: ____

____

Sleep Center Physician Signature: _________________________________ **Date:** ___________________

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