MedStar Georgetown University Hospital

Georgetown University Hospital
Sleep Disorders Center

3800 Reservoir Road, NW
Washington DC, 20007
5th Floor Main Building #5411

Dear:

You have been scheduled for a sleep study on:

Appointment Date and Time: @ 8:30pm
Discharge Date and Time: @ 6:00 am

You will be staying in the "Sleep Disorders Center" overnight; we have enclosed additional information for your reference. If a questionnaire is enclosed, please fill it out and bring it with you to your appointment.

The sleep study or polysomnogram is non-invasive and painless. Electrical sensors are attached by wire to monitoring devices that are used to document brain wave activity eye movements, chin muscle, leg movements, oxygen saturation and respiratory activity. These painless sensors are applied temporarily with gauzes and tape. The equipment may be minimally uncomfortable, but does not prevent sleep or interfere with a meaningful sleep study. It is preferred that at least six hours of testing be obtained in order to provide a comprehensive sleep evaluation for the Doctor. Once the study has started, you have the right to discontinue the test for any reason; however, please be aware that a shorter test may not be as reliable or as useful for the interpreting physician. The full charge for the study will be submitted for payment. Sleep Center patients cannot stay in the lab and sleep without properly being monitored.

We will verify your insurance program and benefits; however, some insurance providers require a Physician's referral prior to scheduling, which must be obtained by the patient. If a referral is required, we will request it at the time of scheduling. If we do not receive the necessary Pre-Authorization and/or Referral, your appointment may be rescheduled. Please note that a sleep study is not considered an inpatient hospital stay, but rather is an overnight outpatient diagnostic test. In the event that your insurance company asks about procedure codes or "CPT" codes, please give them whichever of the following is applicable:

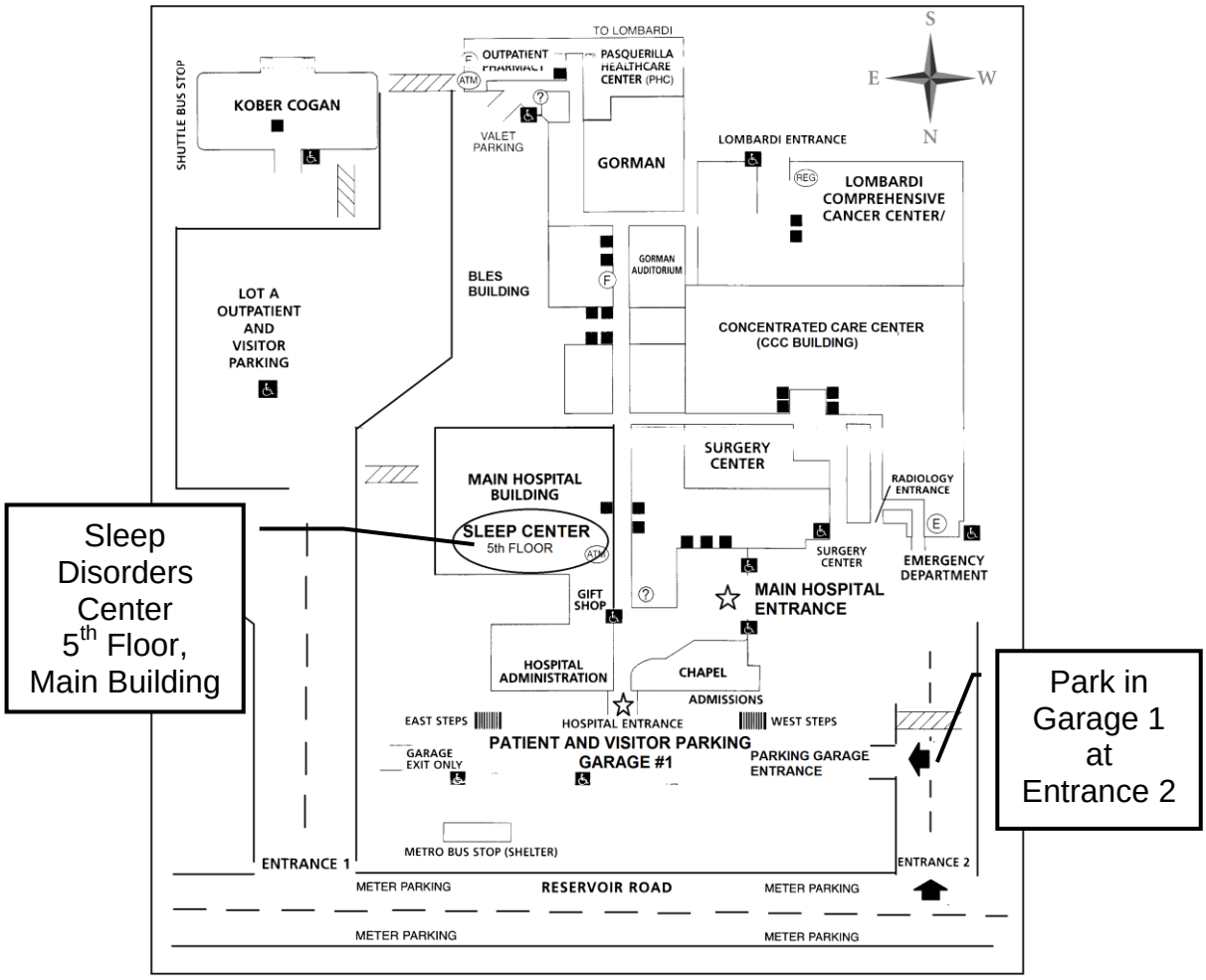
Diagnostic Sleep Study:	CPT 95810
Sleep Study with Nasal CPAP Treatment:	CPT 95811
Split Night PSG with CPAP:	CPT 95811
Multiple Sleep Latency Test (MSLT):	CPT 95805

We are an outpatient department, and patients will be assigned a room according to the type of study that their physician has ordered. Rooms with bathrooms cannot be requested in advance. In most rooms, bathrooms are located inside the room, but in some cases they are adjacent or across from the sleep rooms. Although the restroom may not be in the bedroom, every patient room has access to a restroom with a shower.

Please keep in mind that these appointments are scheduled in advance and much preparation goes into scheduling these appointments. It is very important that you arrive on time for your appointment. If a change occurs in your schedule we would appreciate 24 hours notice of appointment cancelations or rescheduling. Please also note that *if you are sick on the date of your appointment, the appointment should likely be rescheduled* in order to ensure the most accurate test results.

The contact number for appointment confirmation, cancelations and rescheduling is 202-444-3610. The office hours are Monday through Friday, 8:00 am to 4:30 pm. To inform us of an unexpected after-hours cancellation of an appointment, page (202) 405-5438.

When driving to the Hospital: You should enter the Hospital campus by Entrance 2 (look for the Emergency Room sign on Reservoir Road) and park in Garage 1(See the map below). Please bring your parking ticket into the Hospital for validation. Validated parking costs $6 - $12. Handicapped Parking is available in Garage 1. The Sleep Center is located on the 5th floor of the Main Hospital Building. After parking, enter the hospital through either of the Main Building entrances, which remain unlocked until 9:00PM.



Departure: Testing is usually complete at approximately 6:00 a.m. at which time all monitoring devices are removed and you may leave the Sleep Disorders Center. If you need to leave by a specific time, please inform your Technologist. Shower facilities are available.

Results: The results of your test will be sent to your referring physician. Contact the office of your physician to schedule an appointment to discuss results of the study. All results are confidential and will be shared only with you through your physician. Technologists cannot convey any tests results after testing as the study must be reviewed by a physician. Final results generally are forwarded to the ordering physician in 7-10 business days.

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Please keep the following in mind when preparing for your sleep study:

- Shower and shampoo your hair on the day of your study. Hair should be clean and free of any hair spray, mousse, gels, oils, etc. If you have a hairpiece that is glued to the scalp, we may be unable to conduct the test (single braided hair and most hair extensions do not pose a problem).
- Gentlemen should plan on shaving prior to the study. You are not required to remove a mustache or beard.
- NO naps during the day on the day of your study.
- NO caffeinated beverages after 12:00 noon on the day of your study, or during testing.
- NO alcoholic beverages on the day of your study. Please note that Georgetown University Hospital is a tobacco-free campus.
- NO facial make-up, face creams or skin products on your face.
- If you have acrylic/artificial nails on your fingers, you must remove at least one for the study. If you have nail polish or acrylic nails on when you arrive for your study, the Technologist will have to remove the nail polish and/or the acrylic nail from one finger. This is necessary for accurate oxygen saturation readings during the study.
- Eat dinner prior to arriving for your appointment. You may bring a snack if you will be hungry prior to the beginning of study.

Remember to Bring:

- Medication you normally take, including non-prescription medications. The Sleep Disorders Center cannot provide any medications. Take your prescription medications unless instructed otherwise by your physician. If you regularly use sleeping medications, bring them with you.
- Comfortable sleepwear - preferably pajamas or shorts and a top. Sleepwear is not optional – it is required. Please, no satin or satin-like material.
- Personal items such as toothbrush, toothpaste, brush and comb.
- Bring a pillow, if you prefer your own. White noise machines are acceptable.
- If you are currently a CPAP user, bring your mask.
- Reading material or something to keep you busy before bedtime
- Your insurance card and picture identification.

Please note: If you have any special nursing needs or disabilities and need special assistance, please bring your care-giver with you to your appointment. Also, please keep in mind that Georgetown University Hospital is a smoke free campus.

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Sleep History Questionnaire

Patient Name_____**Height**_____**Weight**_____

1. Do you have trouble getting to sleep at night? □never □rarely □sometimes □frequently
2. On the average, how long does it take you to fall asleep?_____
3. Are you bothered by frequent awakenings? □Yes □No
4. On the average, how often during the night do you wake up? _____
5. Are you bothered by long periods of wakefulness during the night?
   □never □rarely □sometimes □frequently
   If yes, how much time altogether do you spend in such periods of wakefulness during the night?
   _____
6. Are you bothered by waking up too early and not being able to get back to sleep?
   □never □rarely □sometimes □frequently
7. Are you bothered by nightmares? □never □rarely □sometimes □frequently
8. Do you awaken from sleep short of breath? □never □rarely □sometimes □frequently
9. Do you snore loudly enough that your spouse, or others complained about it?
   □never □rarely □sometimes □frequently
10. How many nights a week, if any, do you have a sleep problem?
    □never □rarely □sometimes □frequently
11. On the average, how long do you actually sleep at night?
    □>4 hours □4-6 hours □6-8 hours □8-10 hours □10+ hours
12. Do you feel tired during the day? □never □rarely □sometimes □frequently
13. Do you have any health problems? Please describe. _____

    _____

    _____
14. Do you take any medications (pills, shots, vitamins, herbs, etc.)?
    If yes, list below the names and amounts of all medications you are taking and state how often and why you take each one.

Medication	Dose	How often	Reason

15. Write in the average amount of each of these beverages that you drink per day.

Beverage	Amount per day
Regular Coffee	
Decaffeinated Coffee	
Tea	
Carbonated Soft Drinks	
Alcoholic Beverages	

16. How long have you had your sleep problem?_____

17. Do you take naps? □never □rarely □sometimes □frequently

18. Did you nap today? If so, at what time? □Yes □No time: _____

19. Are your sleep habits on weekends different from those of the rest of the week? □Yes □No

20. What time do you usually go to bed and get up?

Weekdays	Get up	AM	PM
	Go to bed	AM	PM
Weekends	Get up	AM	PM
	Go to bed	AM	PM

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing **2 = moderate chance of dozing**
1 = slight chance of dozing **3 = high chance of dozing**

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	

21. Do you ever feel confused when you awaken from sleep? □never □rarely □sometimes □frequently

22. Do you feel refreshed after a short (10 to 15 minutes) nap? □never □rarely □sometimes □frequently

23. How many times per week does your sleepiness appear to be worse? _____

24. Does your sleepiness occur at fairly predictable intervals? □never □rarely □sometimes □frequently

25. Do you awaken in the morning with headaches? □never □rarely □sometimes □frequently

26. Do other people tell you that you have a restless sleep? □Yes □No

27. Have others noticed that you have become increasingly irritable or short-tempered? □Yes □No

28. Has your sexual activity decreased recently? □Yes □No

29. Do you find that your mind is not working as quickly or effectively as it used to? □Yes □No

30. When you awaken in the morning, how long does it usually take for you to begin functioning normally?
□ 0-15 min. □ 15-30 min. □ > 30 min.

31. Do you perspire a great deal at night? □never □rarely □sometimes □frequently

32. When you are angry or laugh, do you ever feel weak, as though you might fall?
□ never □rarely □sometimes □frequently

33. Do other members of your family have sleeping problems? □Yes □No

34. Describe how you feel when you wake up in the morning. _____

_____

35. Do your ankles ever swell? Do you have trouble getting your shoes on and off?
□ never □rarely □sometimes □frequently

36. Do you have difficulty with your sexual functioning □never □rarely □sometimes □frequently

37. Are you in good health? □Yes □No

38. Date of last complete physical examination: _____

Examining physician's name:_____

Physician's address:_____

Office telephone number:_____MD's specialty:_____

39. Was anything found wrong in your last physical examination? □Yes □No

If yes, describe:_____

_____

Other Remarks:

If there are any other aspects of your sleep problem which you feel are important; please describe them below.