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.
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.
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.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>How often</th>
<th>Reason</th>
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<tbody>
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15. Write in the average amount of each of these beverages that you drink per day.

<table>
<thead>
<tr>
<th>Beverage</th>
<th>Amount per day</th>
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<tbody>
<tr>
<td>Regular Coffee</td>
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</tr>
<tr>
<td>Decaffeinated Coffee</td>
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</tr>
<tr>
<td>Tea</td>
<td></td>
</tr>
<tr>
<td>Carbonated Soft Drinks</td>
<td></td>
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<tr>
<td>Alcoholic Beverages</td>
<td></td>
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</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Weekdays</th>
<th>Get up</th>
<th>AM</th>
<th>PM</th>
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<tbody>
<tr>
<td>Go to bed</td>
<td>AM</td>
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<table>
<thead>
<tr>
<th>Weekends</th>
<th>Get up</th>
<th>AM</th>
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<tbody>
<tr>
<td>Go to bed</td>
<td>AM</td>
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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.

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