Welcome to Inova Neurodiagnostic and Sleep Centers

Full Name: _____

Appointment Date: _____ **Appointment Time:** _____

Appointment Location: _____

This letter is to confirm your appointment at one of our Inova Neurodiagnostic and Sleep Center locations. Please read this packet carefully and follow the instructions.

You are scheduled for an overnight sleep study. Please bring **your photo ID**, **insurance card** and this packet (completely filled out) on the night of your sleep study.

For our Alexandria, VA location, please follow these driving instructions:

Inova Neurodiagnostic and Sleep Assessment Center – Alexandria is located inside Inova Alexandria Hospital, which is conveniently located off I-395 at 4320 Seminary Rd., Alexandria, VA 22304. When you arrive, park your car in the Howard Street lot or in the parking lot across from the Cancer Center. Then, go to the Outpatient Registration area to complete your registration. **You must register prior to arriving at the sleep lab**.

For our Fairfax, VA location, please follow these driving instructions:

Inova Neurodiagnostic and Sleep Assessment Center – Fairfax is located at the Woodburn Medical Center, which is conveniently located off I-495 and Gallows Road at 3289 Woodburn Rd., Suite 280, Annandale, VA 22003. From Gallows Road, turn onto Woodburn Road. The building is the first one on the left. When you arrive, park your car in the front of building.

Use the main building entrance. Once inside the sliding doors, use the keypad (call box) on the right side. Press the # key, then enter the code 280. The technician will confirm you are scheduled for an appointment and then unlock the doors for you to enter.

If you cannot keep this appointment, please notify the Inova Sleep Disorders Program call center at 703.504.3220 within 48 hours of your appointment. You are responsible for any portion of your bill that is not covered by insurance. Your insurance will be billed separately by a physician for the interpretation of your study.

Please read and follow the instructions in this packet carefully. Your scheduled sleep test is extensive, and you must follow certain protocols to ensure proper testing. For that reason, the quality of your sleep study depends upon your cooperation and compliance. Unless you are scheduled for a multiple sleep latency test (MSLT), you will be discharged between 5:30 and 6 a.m.

If you have any questions, please call 703.504.3220 between 9 a.m. and 5 p.m.

How Should I Prepare for My Sleep Study?

- ☐ **Documents:**
  - Bring your insurance card and photo ID or driver's license to register for your sleep study.
- ☐ **Sleepwear**
  - Bring a loose-fitting cotton t-shirt and shorts or pajamas (no silk or satin). You are video recorded during the study and must wear sleepwear during the test procedure.
- ☐ **Any Other Personal Articles:**
  - Bring clothes for the next day, personal toiletry articles, something to read (if you wish) and any other personal items you may need. A television is available. If you are scheduled for an MSLT, please feel free to bring magazines, office work, or personal iPad/tablet to watch movies.
- ☐ **Medications:**
  - Bring all medications with you that you will need the night of the study or the next morning.
  - If you are currently taking sleeping aids or psychogenic medications, talk with your doctor about whether you should continue to take these medications for the sleep study.
- ☐ **Artificial Beauty Items:**
  - Wigs, hair extensions, acrylic nails and any other beauty items **must** be detached to ensure secure and safe application of monitors on scalp and finger. The test results may be altered if these items are attached.
- ☐ **Dietary Restrictions:**
  - Avoid alcohol for at least 24 hours prior to the test. Please feel free to bring your own snacks and beverages, if you wish. The sleep lab provides you with complimentary water.
  - Avoid tea, coffee, chocolate and caffeinated sodas on the day of your scheduled study.
  - Please have dinner before you arrive.
- ☐ **Sleep Schedule:**
  - Try to maintain your sleep schedule the day before the study, and try not to take any naps during the daytime. You should remain awake 12 hours prior to the sleep study.
- ☐ **Personal Care:**
  - Shampoo your hair the morning of your study (do not use gels, sprays, grease, etc.)
- ☐ **The Morning After the Study:**
  - You may want to consider making plans to go to work late the morning after the study. Unless you are scheduled for an MSLT, we ask you to be ready to leave no later than 6:30 a.m.

MSLT Patients Only

Patients having an MSLT should come prepared to spend the entire day at the center following their night study. Patients should not make any plans until after 3 p.m. on the day of their MSLT.

Coffee is available and lunch will be provided. Any dietary requests should be made during the appointment.

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Frequently Asked Questions

What will happen when I first arrive at the center?

When you arrive at the center, you will be asked to change into your pajamas. Next, a series of monitoring devices will be applied to your body. While you sleep, these monitors will record your brainwaves, airflow, chest movement and oxygen levels.

Will the monitoring devices be uncomfortable?

Some of the recording devices may be mildly uncomfortable at first, but after wearing them for a while, you will probably not even notice them. Should any of the devices be too uncomfortable, please let the technologist know before the study begins so they may adjust them.

Will I be able to sleep with all of the monitoring devices attached to my body?

Most people sleep very well. The monitoring devices are applied so that you can turn and move around in your sleep. Our goal is to make you as comfortable as possible. If you have any special requests, please let us know in advance.

Will I be given any medications to help me sleep?

No, we will not give you any medications to help you sleep. However, you may bring any medications you will need the night of the study or first thing in the morning. Please list all of the medications you are taking and the dosages on the medication list in this welcome packet.

Note: If you are currently taking sleeping aids or psychogenic medications, talk with your doctor about whether you should continue to take these medications for the sleep study.

Who will be at the sleep center at the time of my sleep study?

You will be met in the sleep lab by one of our specially trained technologists. Our staff is trained to not only obtain quality studies, but also to try to make your stay as pleasant as possible. The center's bedrooms are designed to feel as close as possible to a home-like atmosphere. To ensure your comfort, the rooms are private and temperature controlled. Should a medical emergency arise, a medical staff member is always on call.

Sleep and Sleep-Related Behavior Questionnaire

Name: _____ **Date:** _____

Height: _____ **Weight:** _____

This questionnaire includes a broad range of questions related to your sleep and sleep-related behaviors. Your answers will help us develop a clear picture of your sleep-waking cycle. It will also help us clarify any problems that may be occurring. It is recommended that you complete this survey with the help of your spouse or bed partner, since some aspects of your sleep behavior may be unknown to you. Your careful attention to the questions will help greatly in your sleep evaluation.

1. How many hours of sleep do you get in a typical night? _____hrs.
2. Are you always tired? Yes_____ No_____
3. Are you currently getting too little sleep? Yes_____ No_____
4. Are you currently having difficulty falling asleep and staying asleep? Yes_____ No_____
5. Please give a brief description of your most bothersome symptoms:

   _____

   _____
6. At what time do you usually go to bed on workdays? ____a.m./p.m.
7. At what time do you usually wake up on workdays? ____a.m./p.m.
8. How long does it take you to fall asleep once you decide to go to sleep? ____min.
9. During which part of the night do you wake up most frequently? (check one)

   First part_____ Middle part_____ Last part_____

   Reason:_____

   _____
10. How do you feel when you wake up in the morning? Circle all that apply:

    Drowsy Sleepy Alert Energetic Low-energy Irritable Optimistic Depressed Confused Refreshed

11. Do you dream? If yes, how many times a night? _____

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12. Nocturnal behavior – **Circle** any of the following nighttime behaviors that have occurred in the past year that either you or someone else has noted:

Walking in your sleep	Talking in your sleep	Bedwetting	Grinding your teeth
Twitching or jerking of the legs or arms	Large body jerks	Restless sleep	Rolling or rocking movements
Falling out of bed	Shouting, screaming or swearing	Violent movements	Waking up with a feeling of "terror"
Waking up with great anxiety or tension	Sleep paralysis (being awake in bed but not being able to move or speak)	Coughing	Asthma
Loud snoring	Lapses in breathing (apnea)	Periods of no breathing	Heart palpations
Waking up gasping or choking	Waking up with chest pains	Waking up with painful erection	Waking up with the feeling of "pins and needles" or restlessness in legs
Waking up hungry	Waking up with frequent urge to urinate	Excessive sweating	Waking up with frightening images
Waking up with the feeling of weight on chest	Waking up with a headache in the morning	Other: *Please describe*	

13. Have you sometimes fallen asleep at work? Yes____ No____
14. Have you had a car accident due to being drowsy? Yes____ No_____
    If so, when: Date:_____ Time of day:_____
15. Do you ever have sleep attacks during the day with periods when you cannot prevent yourself from falling asleep? If yes, how often? _____ At what time? _____
16. Do you ever have cataleptic attacks? For example, episodes in which you suddenly feel weak in the legs and/or collapse? If yes, how often? _____ Reason: _____
17. Do you take a daytime nap? If yes, how often? _____ How long? ____ At what time? ____
18. Do you feel refreshed after a nap? Yes____ No____
19. When you are away from home, do you sleep less well or have more sleep disturbance? Yes___ No ___
20. Do you have a job that involves shift work or rotating shifts? Yes ___ No ____
21. Does any member of your extended family have a sleep problem? Yes ___ No ____
22. Please describe a typical night for you:
    _____
    _____

Signature: _____ **Date:** _____

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Medication List

Name: _____ **Date:** _____

Please list all medications, both prescription and over the counter.

	Medication	Dosage	Frequency	Reason for Medication
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

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What Happens After Your Sleep Study?

Your sleep study will be evaluated and interpreted by a board-certified sleep physician. Based on these findings, we will determine an individualized treatment plan for you.

What is the next step?

Please contact the sleep physician or referring doctor to go over the results of your sleep test. Normally, the results will be available about **two weeks** after your study.

Key medical terms to discuss with your doctor:

AHI: The apnea-hypopnea index or apnoea-hypopnoea index (AHI) is an index used to indicate the severity of sleep apnea. It is represented by the number of apnea and hypopnea events per hour of sleep. Apneas are pauses in breathing, and hypopneas are episodes of decreased breathing that affect oxygen.

RERA: Respiratory effort related arousal is a breathing event that causes an arousal or a decrease in oxygen saturation, without qualifying as an apnea or hypopnea.

SAO2: SAO2 stands for **oxygen saturation**, which is the fraction of oxygen-saturated hemoglobin relative to total hemoglobin (unsaturated and saturated) in the blood. The human body requires and regulates a very precise and specific balance of oxygen in the blood.

TST: Total sleep time represents the entire time spent sleeping and is the sum of the deep sleep duration, light sleep duration and REM sleep duration.

AHI Scale:

AHI 5 - 15 = Mild Sleep Apnea

AHI15 - 30 = Moderate Sleep Apnea

AHI > 30 = Severe Sleep Apnea

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Durable Medical Equipment Resources

(Applicable to CPAP & BIPAP patients only)

Your doctor has determined that you need to use a continuous positive airway pressure (CPAP or BIPAP) machine. These machines are provided by a durable medical equipment (DME) company that participates with your insurance company. You will need to contact your insurance company to see which DME company they use.

When you find a DME company that can provide the machine, they will need the CPAP prescription that your doctor gave you at your office visit. The DME company may also need a copy of your physician's office note and a copy of your sleep study. Please contact your sleep doctor's office and they will fax the information to the DME company. They will take care of all insurance requirements and authorizations. The DME company will contact you directly to have your machine delivered to your home and show you how to use it.

Please direct all future questions about your machine or equipment needs to the DME company.

The following is a list of DME companies in the area:

- American Home Patient: 703.644.1016
- America's Healthcare @ Home: 800.545.6026
- Apria Healthcare: 703.642.3141
- Bay State Medical: 866.883.9770 (does not take Medicare)
- Lincare: 703.263.0770
- MediHome Care: 703.321.2834
- Mid Atlantic Healthcare: 800.946.9943
- Neighborcare: 301.362.7600
- Respira: 866.373.7744
- Respicare: 703.440. 3600

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Sleep Diary

Name: _____

This sleep diary is designed to assess the pattern of your sleep. Please fill this out every day and write the date on the top. We realize that some information requested is not going to be exact. We ask that you fill it out as best as you can.

	Date	Date	Date	Date	Date	Date	Date
What time did you go to bed?							
What time did you wake up?							
How many times did you wake up during the night?							
Why did you wake up during the night?							
Quality of sleep upon awakening (excellent, good, fair, poor)?							
How did you feel when you woke up?							
How many cups of coffee did you consume? (if any)							

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Sleep Diary

Name: _____

This sleep diary is designed to assess the pattern of your sleep. Please fill this out every day and write the date on the top. We realize that some information requested is not going to be exact. We ask that you fill it out as best as you can.

	Date	Date	Date	Date	Date	Date	Date
How many cups of tea did you consume? (if any)							
How much alcohol did you consume? (if any)							
How many cigarettes did you smoke? (if any)							
Did you take a nap(s)? (Mark Yes or No) If yes, how many/how long? (Write # followed with hours, e.g. two naps for 5 and 7 hours							
Any other comments?							