




ALASKA
SLEEP CLINIC

*3920 Lake Otis Parkway, Suite 1
Anchorage, AK 99508*

*Phone: (907) 770-9104
Fax: (907) 770-8965*



You have been scheduled for a sleep study at **Alaska Sleep Clinic**. In this packet you will find information and questionnaires regarding procedure for your study. Please complete the following questionnaires and bring them with you on the day of your appointment. If you need to cancel an appointment, please do so at least 24 hours in advance.

You have been scheduled for: _____ at _____ PM.
Please do not arrive early without calling ahead.

- **If you need to reschedule or cancel your appointment 48 hours notice would be appreciated so your appointment time can be filled.**

It is important for anyone who is feeling sleepy to avoid driving or operating any machinery that can place themselves or others in danger. Sleep apnea, and other sleep disorders, make it much more likely for someone to feel sleepy so patients with these problems should be especially careful about driving.

Enclosed is the following:

1. A general sleep questionnaire that provides a history of your sleeping habits and general information that may affect your sleep.
2. A 7-day diary. If there are not 7 days prior to your study, please fill it out as completely as possible.
3. A bed partner questionnaire to be filled out by someone who has seen you sleep if possible.

Sleep Test Instructions On the day of your test

- Bring your usual Pajamas – preferably tops and bottoms, personal hygiene products, and a favorite pillow or blanket and any personal items (books, magazines, etc.) you would like.
- Remain awake the day of the study – no naps.
- Do NOT drink caffeine (coffee, tea, soft drinks, etc.) after 11:00 AM the day of the study.
- If you take prescription medications, or if your physician has prescribed medications to be taken during your study such as a sleep aid, please bring them with you to the sleep center.
- Please bathe and shampoo your hair before coming to the Sleep Center. Do NOT put any conditioners, hair spray or oils on your hair so electrodes will remain attached.
- Please have your evening meal before arriving for the sleep study.

What is a Sleep Study (Polysomnography), and what does it measure?

A sleep study is a test that measures bodily function during sleep. Each test will vary depending on the individual. Some parameters measured are:

1. Brain waves (skin surface electrodes on the head); this is measured to determine if one is awake or asleep, and what stages of sleep a person is in.
2. Eye movements (skin surface electrodes above and below the eyes).
3. Muscle tension (skin surface electrodes on the chin).
4. Leg movements (skin surface electrodes on the lower legs).
5. Breathing (respiratory belts which measure chest movement and effort to breathe).
6. Snoring (measures amplitude of snoring).
7. Blood oxygen levels (small sensor attached to the finger; no blood will be drawn).
8. Video recording (infrared cameras in room to observe patient sleeping).

Note: All of the above parameters are non-invasive and painless.

What to expect

- When you arrive in the Sleep Clinic, the technician will apply several electrodes and sensors to your head and other parts of your body. This process will take a little time, so you will not be able to go to bed as soon as you arrive.
- You will be allowed to go to sleep in a private room. The technician will be present all night to monitor breathing, heart rate, brain wave activity and body movements during sleep.
- TV and radio are not allowed once the test has begun.
- The actual test will be a minimum of six hours.
- After the sleep study is completed, you will be able to leave, if no other testing has been scheduled.
- If you are staying for a daytime test, breakfast and lunch will be provided.
- A Sleep Physician, will analyze your test results. Their report will be sent to the physician who referred you to **Alaska Sleep Clinic**.

Why record all this information?

All of the parameters will give your physician the information he/she needs in diagnosing your sleeping problem. When people sleep many or all of these parameters change and could be causing disrupted sleep. If sleep is disrupted, this may lead to other medical problems.

How am I going to sleep with everything attached to my body?

Surprisingly, most people are able to fall asleep without any difficulty. The technologist takes great care in applying the electrodes to ensure both quality sensor readings and to make you as comfortable as possible. The sensors are applied so that you can turn and move while you sleep, and you will be able to use a restroom if needed. In most instances, you will be unaware of the sensors after having them on for a short while.

We hope this information has been helpful. For further questions, call 907-770-9104.



Have you ever had a sleep test before? Yes No

If you answered Yes above please complete this form:

1. When was your original sleep test done? _____

2. Where was your original sleep test done? _____

3. What were the results? _____

You must provide a copy of the original sleep report if it was not done at **Alaska Sleep Clinic**
– If possible.

4. Are you currently using a CPAP or BiPAP machine at home? YES NO

If yes – please indicate the brand of machine, the model, and how old it is:

5. What is your treatment setting? _____

6. Do you expect to be replacing your old machine? YES NO

Please bring your machine with you to your appointment to have it tested.

7. What type of mask are you using, how old is it, and are you happy with its performance?

Please describe why you are being re-tested:

Alaska Sleep Clinic
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Financial Policy

I hereby authorize Alaska Sleep Clinic to render whatever services are deemed necessary for my medical care, with the understanding that I can defer services that are suggested by my physician. I understand that if my insurance company refuses payment for any reason that I am financially responsible for the services that were provided (including charges my insurance company claims are “above usual and customary”). If my insurance company does not pay on my account within 90 days, the balance becomes my responsibility.

Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices***. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I acknowledge that I have read and understand the above Financial Policy and Notice of Privacy Practice.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient’s signature in acknowledgement on this ***Notice of Privacy Practices Acknowledgement***, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____



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Release for Photograph and Video Recording

In the interests of science and the furtherance of medicine and health care, I, the undersigned, consent to and authorize photography, video recording and/or audio recording to be done during the testing procedure by the employees of **Alaska Sleep Clinic**.

I further authorize such subsequent use of the photograph; members of the faculty of the sleep center may deem video and/or audio information as advisable in their sole and absolute discretion for the furtherance of medical science, education and/or practice. I consent to the presentation of all relevant medical information and clinical demonstration concerning my/this case to students of medicine and allied health sciences, to medical professional groups and to possible publication thereof in scientific literature. Anonymity of the subject(s) will be insured.

The contents of this release were read and understood by the undersigned subject.

Signature of the Subject

Date and Time

Signature of Witness

Date and Time

Signature of a Guardian

Date and Time

Guardians Signature is necessary when a subject is a minor or otherwise unable to sign on their own behalf:

Guardian's Relationship to Subject: _____

7-Day Sleep Diary

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Date:							
I went to bed last night at ____:____ (time):							
I got out of bed at ____:____(time):							
Last night, I fell asleep in ____ (Mins):							
When I woke up for the day I felt:	Refreshed Somewhat refreshed Fatigued	Refreshed Somewhat refreshed Fatigued	Refreshed Somewhat refreshed Fatigued	Refreshed Somewhat refreshed Fatigued	Refreshed Somewhat refreshed Fatigued	Refreshed Somewhat refreshed Fatigued	Refreshed Somewhat refreshed Fatigued
Last night I woke up ____ times:							
My sleep was disturbed by:							
Number of caffeinated beverages in the morning:							
Number of caffeinated beverages in the afternoon:							
Number of caffeinated beverages in the evening:							
I exercised 20 mins or more at ____:____ (Time):							
Number of alcoholic beverages before bedtime:							
Medications I took during the day:							
I did what activity within an hour before bed:							

Alaska Sleep Clinic - Questionnaire

Patient Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Marital Status: _____ Referring Physician _____

Why Are You Here? (Reason for the study in your own words): _____

Sleep Schedule

- | | | |
|--|-------------------|-------------------|
| 1. What time on weekdays do you usually
What are your usual working hours if applicable | Go to bed ? _____ | Wake up? _____ |
| 2. What time on weekends do you usually | Begin? _____ | End? _____ |
| 3. On average, how long do you actually sleep at night? | Go to bed? _____ | Wake up? _____ |
| 4. Do you feel that you get too much or too little sleep at night | Weekdays? _____ | Weekends? _____ |
| | Too much? _____ | Too little? _____ |

Night Time Symptoms

- | | |
|--|-------------------------------------|
| 5. How long does it normally take you to fall asleep at night? | Mins _____ |
| 6. Do you have thoughts that prevent sleep? | Yes _____ No _____ |
| 7. Do you have trouble getting to sleep at night? | Yes _____ No _____ |
| 8. Do you awaken at night to use the bathroom? | Yes _____ No _____ How often? _____ |
| 9. Are you ever awakened by a "coughing spell" during the night? | Yes _____ No _____ |
| 10. Do you have crawling sensations in your legs while falling asleep? | Yes _____ No _____ |
| 11. Do you have twitching movements in your legs during the night? | Yes _____ No _____ |
| 12. Do you awaken with racing thoughts, sadness or anxiety? | Yes _____ No _____ |
| 13. Have other people told you that you have restless sleep? | Yes _____ No _____ |
| 14. Do you have difficulty going back to sleep during the night? | Yes _____ No _____ |
| 15. Does anyone tell you, you snore badly? | Yes _____ No _____ |
| 16. Do you have difficulty breathing at night? | Yes _____ No _____ |
| 17. Do you wake up with headaches? | Yes _____ No _____ How often? _____ |
| 18. Do you awaken with a sour or bitter taste in your mouth? | Yes _____ No _____ How often? _____ |
| 19. Is it difficult for you to awaken and get out of bed after sleeping? | Yes _____ No _____ How often? _____ |
| 20. Have you experienced paralysis upon awakening from sleep? | Yes _____ No _____ How often? _____ |
| 21. Do you have vivid dreams as you are falling asleep? | Yes _____ No _____ How often? _____ |
| 22. Is your sleep disturbed by a medical problem (Y/N)? _____; Describe: _____ | |

Day Time Symptoms

- | | | | | |
|--|-----------|----------|------------------------------|----------------|
| 23. Do you deliberately take naps during the day | Yes _____ | No _____ | How often? _____ | How Long _____ |
| 24. Do you feel rested or refreshed after a nap? | Yes _____ | No _____ | | |
| 25. Are you bothered by sleepiness during the day? | Yes _____ | No _____ | How often? _____ | |
| 26. Do you find yourself falling asleep when you don't mean to? | Yes _____ | No _____ | How Long _____ | |
| 27. Do you take naps during the day? No Need _____ I want to but can't _____ | | | Number of times a week _____ | |

28. Do you fall asleep during these situations?

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

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place?	0	1	2	3
As a passenger in a car for an hour with out a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

_____ Total

29. Have you noticed, or been told about, any changes in your personality recently, such as:
- | | | | |
|---------------------|--------------------|-------------------------------|--------------------|
| a) irritability | Yes _____ No _____ | e) loss of concentration | Yes _____ No _____ |
| b) increased temper | Yes _____ No _____ | f) "spaced out" feeling | Yes _____ No _____ |
| c) anxiety | Yes _____ No _____ | g) decreased job productivity | Yes _____ No _____ |
| d) depression | Yes _____ No _____ | h) poor memory | Yes _____ No _____ |

30. Have you ever had the following kinds of weakness develop suddenly during an emotional situation (for example, when laughing, if angry, if in an exciting situation, etc.)? (Check one on each line):

	Never	1-5 times in your life	Monthly	Weekly	Daily - almost daily
Knees buckling					
Mouth opening					
Head nodding					
Falling down					

Do you know, or others tell you that you:

	Age Started	Last Occurred	Frequency	Treatment
Talk while apparently asleep?				
Walk while apparently asleep?				
Grit teeth while apparently asleep?				
Wake up screaming, anxious or afraid?				
Have disturbing dreams (nightmares)?				
Have unusual movements while asleep?				

- Health History
- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> Weight Problems | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sinus Surgery | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Neurologic Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Colitis | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Narcolepsy |
| <input type="checkbox"/> Deviated nasal septum | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Dementia | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> Fibromyalgia |
| | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Parkinson's |

31. Please list any other health or surgical history _____

If anyone in your family had sleep problems, please list the problem & your relationship _____

Medications Please list below or attach to the back of this questionnaire

Medications	Amount	How Often	Years	Reason	Medications	Amount	How Often	Years	Reason

32. For each of the beverages listed below, please write the average amount you drink daily:
 Regular coffee(Cups)_____ Hot or iced tea (Cups) _____ Caffeinated soft drinks ____
33. Do you smoke cigarettes (Y/N)? _____ If YES, how many packs per day? _____ For how many years? _____
34. If NO, did you ever smoke (Y/N)? _____ When did you stop smoking? _____
35. How many alcoholic beverages do you drink per day on weekdays _____ / weekends? _____ or per month _____

If there are any other aspects that you feel are important, please describe them here or on the back of this page.

